



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



MCH Block Grant Application

FY 00-01

Submitted by
North Carolina
Department of Health and Human Services

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Secretary

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1.4 Overview of the State

Demographics

The estimated total state population on July 1, 2000 was 7,617,000, a 14.9 % increase from 1990 census population. African-Americans remain the largest racial/ethnic minority group in the state, however the Hispanic/Latino population continues to rise. Reliable estimates of the size of this population will be available with 2000 census data. NC's Hispanic/Latino population is comprised of several sub-groups. The majority are Mexican or Mexican-Americans who come to the state for agricultural work. Many remain in the state for extended periods, or establish permanent roots here. While the state attracts many highly educated Hispanic/Latino professionals, the majority of the Spanish-speaking population in most counties is comprised of new arrivals with limited English language skills. The impact of this population on the organization and delivery of health care services varies across the state, but can be profound. In some counties, three quarters or more of the women and children seeking personal health services in local health departments are Hispanic/Latino. These agencies are coping with these changes in the face of many obstacles, not the least of which is difficulty in obtaining local support for allocating resources to meet the special needs of this burgeoning population.

Organization and Delivery of Public Health Services

In North Carolina governmental health and social services are generally administered through autonomous county-level governmental agencies (see Table I below). This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level.

TABLE I
North Carolina State Agencies and Local Counterparts

STATE AGENCY / DIVISION		MCH-RELATED PROGRAMS	LOCAL COUNTERPARTS
Department of Health and Human Services (DHHS)	Public Health	Title V, Title X, WIC, dental health, epidemiology, State Center for Health Statistics, blood lead, communicable diseases,	87 county or district health departments
DHHS	Educational Services	Selected early intervention services	18 Developmental Evaluation Centers (DECs)
DHHS	Social Services	Medicaid, TANF (“Work First”)	100 county Departments of Social Services (DSS) offices
DHHS	MH/DD/SAS	Mental health, substance abuse and developmental disabilities services	41 Area Mental Health Programs
Department of Public Instruction		Education, school health	119 local education agencies

Managed care organizations (MCOs) are increasingly important service providers for populations with private health insurance. Although the use of MCOs for delivery of services to Medicaid recipients was implemented in a deliberate fashion, the shift from public to private sector provision of services to the low income population has had a profound impact on local public health agencies who have traditionally served as direct providers of publicly-subsidized primary and preventive health services. The emphasis on public-private partnerships is strong across the state, as “interested parties” determine what services are needed, and who can best provide them. The role of the state agency is to create and maintain state level partnerships, and to provide leadership and consultation to local decision-makers.

1.5 State Title V Agency

1.5.1 State Agency Capacity

Organizational Structure

The North Carolina Title V program is housed within the North Carolina Department of Health and Human Services which is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). H. David Bruton, MD serves as Departmental Secretary. His term will end this year and a new Secretary will be appointed by the incoming Governor who will take office in January 2001.

The DHHS Assistant Secretary for Health and State Health Officer is Dennis McBride, MD, MPH. He has oversight of the three DHHS health divisions: Mental Health, Developmental Disabilities,

and Substance Abuse Prevention; Facility Services; and Public Health. Dr. McBride is also serving as Acting Director of the Division of Public Health with the retirement of Dr. Ann Wolfe on July 1, 2000. The Division of Public Health (DPH) is comprised of the Director's Office and four Sections. (See TABLE II for current organizational charts.) The Director's Office houses units with Division-wide impact, including:

- State Laboratory
- State Center for Health Statistics
- Office of Chief Medical Examiner
- Office of Local Health Services
- Office of Healthy Schools
- DPH Budget Office
- DPH Personnel Office (staffed by DHHS Division of Human Resources)

Other programs and services are operated out of the four Sections: Epidemiology; Chronic Disease Prevention and Control; Oral Health; and Women's and Children's Health.

Program Capacity

The Women's and Children's Health Section (WCHS) is comprised of four Branches as outlined in TABLE II. The Section Management Team, which is comprised of the Chief, Deputy Chief, Special Assistant, and four Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s).

There have a series of changes in the WCHS management team over the past two years. During that time there has been turnover in the Section Chief, Deputy Section Chief, and within three of the Section's four branches (Children and Youth, Women's Health and Immunization). Most of these changes came as a result of the retirement or promotion of seasoned MCH professionals who had served North Carolina for many years. The combination of these transitions, and the organizational changes associated with placement in a new Department and a new Division, have created an on-going series of challenges to the Section.

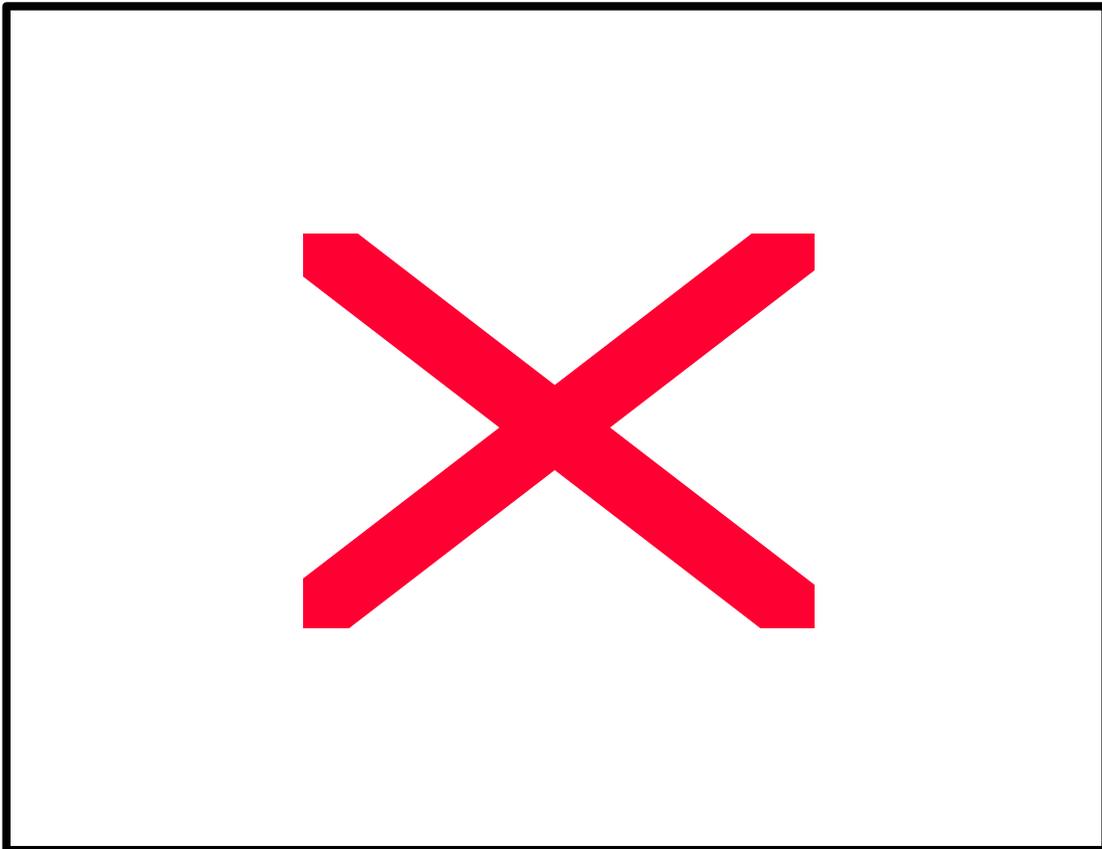
Other Capacity

The Section employs over 200 staff members responsible for management and administration of programs and services for the MCH population, including 70 regional consultants across the state.

The Section does not currently have positions designated for parents of special needs children, however the Children and Youth Branch (C & Y) has an active Parent Advisory Committee that is utilized extensively by the Children’s Specialized Services. The Children and Youth Branch also channels funding through the Family Support Network at the University of North Carolina in Chapel Hill to 13 local family support programs. Local program coordinators attend PAC meetings, provide assistance to local child service coordinators, and help individual families.

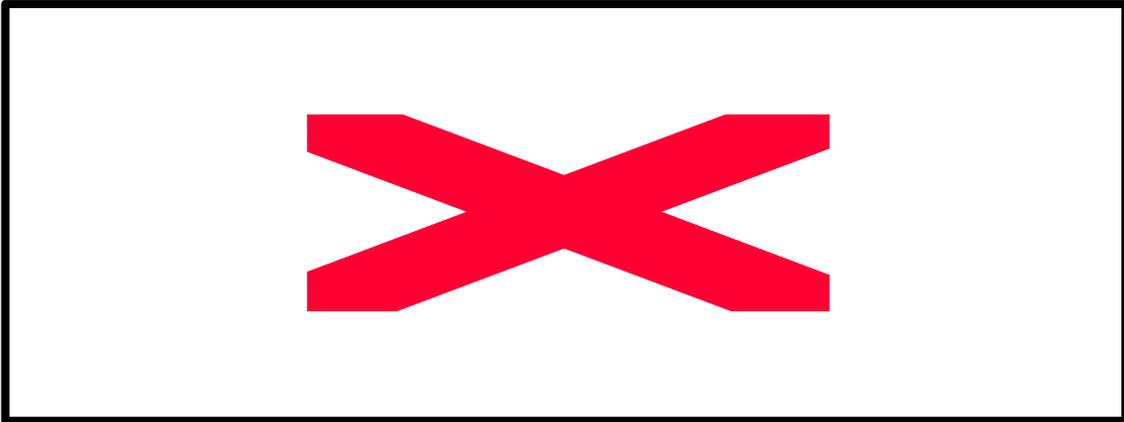
TABLE II
Organizational Charts¹

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES



¹ Official organizational charts which include most recent changes not yet available. This chart roughly depicts organizational placement of MCH in the Department.

DIVISION OF PUBLIC HEALTH



WOMEN'S AND CHILDREN'S HEALTH SECTION

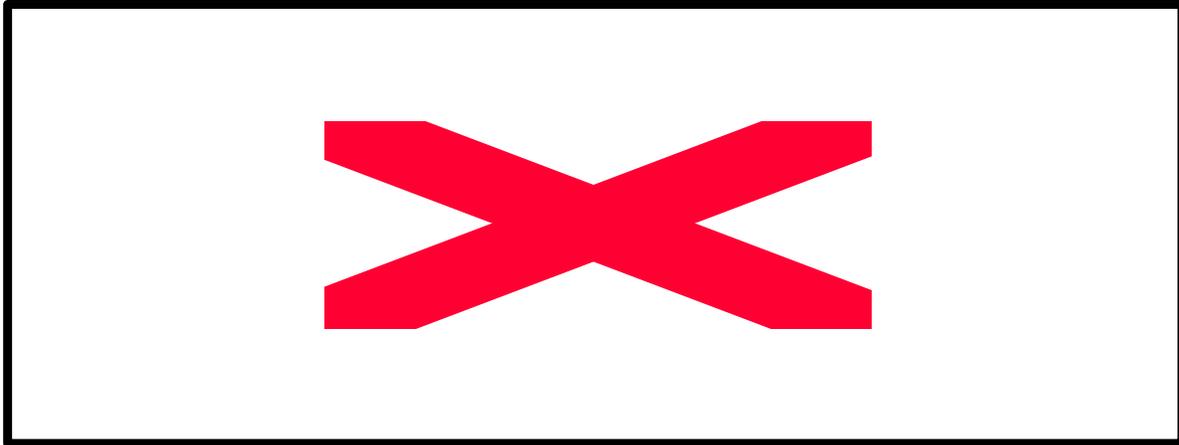


TABLE III
Women's and Children's Health Section
Overview of Programs and Services

BRANCH	POPULATION	UNITS	PROGRAM AREAS
Women's Health	Women and infants	Women's Preventive Health Services	Family planning, interconceptional care
		Maternal Health Services	Perinatal care
		Clinical Support Unit	Clinical policy development, consultation and technical assistance.
Children and Youth	Children (including Children with Special Health Care Needs)	Children's Preventive Health Services	Well child care, school health, child care, child fatality prevention system
		Children's Specialized Health Services	Services for special needs children
		Genetic Health Care	Newborn screening, sickle cell program
Immunization	Children (including Children with Special Health Care Needs)		Vaccine distribution, immunization registry, surveillance and outbreak control of vaccine preventable diseases, public education
Nutrition Services	Pregnant women, infants, children (including Children with Special Health Care Needs)	Administrative Services	WIC vendor contracting, local contracts, Farmer's Market Nutrition Program.
		Special Nutrition Programs	Child and Adult Care Food Program, Summer Food Services Program for Children.
		Field Services and Training	Nutrition consultation and technical assistance, Nutrition Education and Training, local agency nutritionist recruitment.
		Clinical Services	WIC nutrition policy and education, pediatric and pregnancy nutrition surveillance, breastfeeding promotion, outreach.

Key staff members

Section Chief

Dr. Kevin Ryan replaced Dr. Ann Wolfe as Title V Director in March, 1999. He served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an M.P.H. from the UNC School of Public Health, Department of Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Deputy Chief

Dorothy Cilenti assumed the duties of Deputy Section Chief in December 1998. After completing an undergraduate degree in psychology (Duke University, cum laude, 1985), she earned masters degrees in social work and public health from UNC-Chapel Hill in 1989. She has held increasingly responsible positions in state and local public health agencies. Prior to joining the Women's and Children's Health Section management team, she served as Head of the (then) Maternal Health Branch.

Special Assistant

Cheryl Waller serves as Special Assistant for Program Planning and Development. She completed her nursing education at the University of Rochester (NY) in 1975 and earned an M.P.H. from the UNC School of Public Health, Department of Public Health Nursing in 1978. Her public health and MCH experience includes work at the county, regional, state and Federal levels, where she has worked as a nurse practitioner, regional nurse consultant, and program consultant.

Data Specialist/Needs Assessment Coordinator

At time of grant preparation, Section is in final stages of hiring new staff person to coordinate data and needs assessment activities for the Section. That process will be complete by the time of the HRSA Field Office review in August.

Women's Health Branch Head

Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February, 2000. Dr. Holliday has over 25 years of public health leadership experience, including local health director

positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

Children and Youth Branch Head

Carol Tant replaced Tom Vitaglione as Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her M.P.H. in health administration from the UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health and children's health services. Carol's work experience in children's health for over 19 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head

Alice Lenihan earned a B.S. in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a M.P.H. in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Section Chief. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head

Beth Rowe-West assumed the position as Branch Head since December, 1999 after serving in an acting capacity since October, 1998. She earned her B.S. in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

1.5.2 State Agency Coordination

With creation of the Department of Health and Human Services in October, 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development programs are now administered from a single agency. The DHHS Secretary

has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Assistant Secretary for Health conducts regular meetings with the directors of the three divisions that he manages (Public Health; Facility Services; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:

- DHHS Division of Medical Assistance for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement is revised in its entirety every five years, with interim changes as needed.
- Department of Public Instruction (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).
- DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.
- DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes responsibility for informing families of the availability of SSI, eligibility determination (when appropriate) and assurance that children remain under care.
- DHHS Division of Child Development This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.
- Division of Educational Services. This is a newly created Division that houses services for the deaf and blind, and selected early intervention services. Management and oversight of the state's network of 18 Developmental Evaluation Centers was transferred from the Division of Public

Health/WCHS to this Division in March 2000 to consolidate major early intervention programs in a single Division.

At that time an intra-agency work group was established to assure coordinated planning and implementation of DHHS early intervention services. Key staff members from WCHS are included in this workgroup.

WCHS staff assure that information about health and social services is available to the target population by supporting the following toll-free information and referral hotlines:

- Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets IDEA requirements.)
- CARELINE (1-800-662-7030) provides general information about available social services.
- First Step (1-800-FOR-BABY), part of infant mortality reduction public awareness campaign, provides general perinatal information with special emphasis on reaching pre-conceptual and pregnant women. (Database linked to CARELINE.)
- Health Check (1-800-474-9000) and NC Family Health Resource Line (1-800-367-2229) provide information, advocacy and referrals for primary and preventive health services for children and youth.
- Children's Specialized Services line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.

Division of Public Health and WCHS staff work with the state education agency (Department of Public Instruction) on a number of projects including a CDC-funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs.

In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:

- Development and maintenance of school-based and/or school-linked health centers,
- Expansion and enhancement of school nurse services,
- Nutrition and related training for food service workers, and
- Implementation of USDA-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:

- Medicaid Outreach and Education
- Health Check Initiative
- Child Fatality Task Force
- Council on Developmental Disabilities
- IDEA Interagency Coordinating Council
- *Smart Start* Partnership for Children (Governor's early childhood initiative)
- Coalition for Healthy Youth
- Family Preservation / Family Support Initiative
- Healthy Child Care North Carolina
- *Baby Love* Program (enhanced services for pregnant women and infants)
- First Step Campaign (infant mortality reduction)
- Early Intervention Intra-agency Work Group
- WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

II. ANNUAL REPORT

2.1 Annual Expenditures See Section 5.8

2.2 Annual Number of Individuals Served See Section 5.8

2.3 State Summary Profile See Section 5.8

2.4 Progress on Annual Performance Measures

Direct Services: Pregnant Women and Infants

WCHS supports a statewide network of local health department clinics which provided clinical prenatal services to 35,508 women in FY 98-99. These health department clinics have a long-standing commitment to the provision of multidisciplinary perinatal services including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, and postpartum services. A wide range of preventive health services (including family planning services discussed below), are offered in virtually all of these health departments, allowing most clients to receive a continuum of reproductive health services at a single site.

Standards for provision of WCHS supported prenatal and post partum services are based on ACOG/AAP guidelines, with modifications as needed to comply with regulations and requirements specific to North Carolina. Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional nursing and social work consultants who routinely work with agencies within assigned regions.

High Risk Maternity Clinics

In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports 18 high risk maternity clinics (HRMCs) across the state. The “traditional” HRMCs, located at tertiary care centers, are supervised by Maternal-Fetal Medicine specialists with immediate access to state-of- the-art technical support services and subspecialty consultation. These clinics have true regional catchment areas and function as “end providers.” They are equipped to handle the highest risk prenatal clients without need for referral to higher levels of care. The remaining HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care.

At the time of the inception of the HRMC program, the local health department HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care

was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these “intermediate level” HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, the Section continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

Nurse Midwifery Program

The Nurse-Midwifery program provides grants to establish nurse-midwifery services in underserved areas of the state. The program increases the availability of services in specific underserved areas of the state and provides a valuable and viable service provision model for other organizations to replicate.

The program was established in 1989 by the NC General Assembly which provides an annual appropriation of \$400,000. These funds are awarded as “seed money” to local nurse-midwifery projects as they become self-supporting. Funding is available to: “full-scope” projects that employ three or more nurse midwives who care for a group of clients, providing all prenatal, intrapartum and postpartum care; and “single-scope” practices that employ a single midwife, who provides a variety of outpatient services and usually participates in an obstetrical call schedule.

In FY 98-99, awards were made to two single-scope projects and one full-scope project. In addition, two planning grants were awarded to support the planning and local coalition-building shown to be essential to the success of the nurse-midwifery projects.

As part of its commitment to evidence-based practice in the provision of direct clinical services, in FY 98-99, WCHS implemented a revised set of standards for prenatal services in local health departments. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant North Carolina regulations, and are provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists’ *Guidelines for Perinatal Care*. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. The accountability tool developed from these standards could form the kernel of an accountability system for Medicaid and commercial managed care services.

The Section is strongly committed to the idea that when sound scientific evidence exists about effective clinical interventions, great efforts must be taken to maximize the impact of these evidence-based

practices. The Section is currently collaborating with the NC Chapter of ACOG, and the HIV/STD Branch to develop a strategy to improve the level of prenatal HIV counseling and testing practices, especially among the private sector, as an avenue to ensure optimal utilization of antenatal treatment. Increasing provider awareness of the importance of providing anticipatory guidance concerning infant sleep positioning is another area of interest to the Section. The Section also plans to focus on emerging research and interventions to address the racial and ethnic disparity that exist among our fetal and infant mortality, preterm birth, low-birth weight and SIDS rates. The crucial need to identify and disseminate effective strategies to reduce the gap between white and minority birth outcomes will be the focus of an upcoming statewide perinatal forum to be held August 24, 2000, as well as part of a departmental meeting to be held December 12-13, 2000 entitled *The Great Divide: Understanding and Eliminating Health Disparities*.

Direct Services: Children

The Women's and Children's Health Section provides preventive health services to children from birth to 18 years of age primarily through local health department clinics. The schedule of recommended visits is based on American Academy of Pediatrics guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care.

In FY 98-99, nurse screening and pediatric clinics served 140,440 children across the state. Nurse screening clinics are conducted by public health nurses in local health departments. Physicians do not staff these clinics, however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the Children and Youth Branch. In FY 98-99, Branch staff initiated discussions with the state Medicaid program to offer this training to nurses working in settings other than Public Health Clinics. Nurse screening clinic services include:

- Parental counseling regarding good health, nutrition practices and developmental milestones
- Immunizations
- Assessment of proper growth, development, hearing, vision, and speech
- Screening for anemia and lead
- Referrals as needed

Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems

identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

Direct Services: Children With Special Health Care Needs

National Performance Measure #1: Percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from state Children with Special Health Care Needs (CSHCN) program.

Our past reports that fewer than 20% of SSI beneficiaries North Carolina receive CSHS services have been technically correct, but very misleading. In fact, North Carolina provides Medicaid coverage to all elderly, blind and disabled individuals receiving assistance under the Supplemental Security Income Program. The NC child health insurance program (Health Choice) serves as an additional payment source for these children. The Title V program continues to assure that all SSI beneficiaries receive appropriate services.

Each month over 300 referrals of newly eligible SSI children are received by staff in the WCHS/ Children and Youth Branch /Children's Specialized Health Services Unit (CSHS). Children less than five years of age are referred to the Child Service Coordination Program in their local health department for immediate linking to all appropriate services including those of the CSHS program. Older children with chronic illnesses typically covered through the CSHS are also referred to local child service coordinators. The goal is to ensure that, through care coordination, they access all services available to them through sources such as early intervention services, the Infant-Toddler Program, Health Choice and Medicaid.

National Performance Measure #2: Degree to which state CSHCN program provides or pays for specialty and sub-specialty services.

North Carolina has been able to provide all referenced specialty and sub-specialty services since 1995 through Title V and/or other resources. We do not anticipate any changes that will affect our ability to continue to provide these services.

State Performance Measure #3: Percent of children less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.

See Annual Plan.

Additional WCHS Direct Services for Children with Special Health Care Needs

The CSHS program continues to offer diagnostic and limited treatment services through a network of specialty clinics that includes cardiology, neuromuscular, orthopedic, pulmonary, and speech and

hearing services. These clinics served 10,437 children during FY 98-99. Almost three-fourths of them had speech and hearing evaluations and/or treatment.

“Wrap-around” Services

In addition to specialty clinic services, selected “wrap-around” services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians’ care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions. During FY 98-99, services for 2,390 children were reimbursed through this component of the program. About three-quarters of these children were age 10 or under, and half were less than five years of age. Children with developmental delays, speech/language disorders, or cerebral palsy accounted for more than 50 percent of the caseload. Reimbursement for durable medical equipment and supplies accounted for 84 percent of these expenditures.

Post-adoption services

CSHS offers reimbursement of medical bills related to the child’s disability to families who adopt a special needs child. Arrangements for this service can be made while the family is considering adoption, to encourage such adoptions by families that otherwise might be unable to fulfill their dream because of the treatment costs that loom ahead. Currently there are 83 children on the CSHS post-adoption approval list. During FY 98-99, 31 children approved for post-adoption coverage received services through CSHS.

Assistive Technology Program

CSHS assures provision of assistive technology devices (i.e. durable medical equipment, learning and developmental aids, and/or life-sustaining equipment, supplies and materials that have been purchased commercially, modified, customized or adapted that are used to increase, maintain or improve the functional capabilities) for any child enrolled in the North Carolina Infant-Toddler Program. Assistive technology devices can be funded through private insurance, Medicaid, Children's Special Health Services, and/or the CSHS Assistive Technology program.

This program allows families to obtain assistive technology devices through a statewide network of seven Assistive Technology Resource Centers. Staff at the centers provide: assessments by multidisciplinary teams in consultation with family members; training, technical assistance, consultation and public awareness to consumers and professionals; and an equipment lending library for short term loans to families and professionals. During 1996 (the first year formal statistics were collected),

approximately 4,900 children ages birth to five received assistive technology services and/or devices through this CSHS program. The number rose to 5,594 in 1997, and to almost 6,000 in 1998.

Community Transition Coordinators

CSHS funds positions for community transition coordinators at 10 medical centers. These coordinators facilitate seamless transition from hospital to community for infants and children under age five who need assistance in coordinating required medical and social services. The CTCs identify and screen newborn and infant pediatric admissions up to age five to identify children who have, or are at risk for, developmental disabilities. Children are then referred to Infant and Toddler early intervention services, Child Service Coordinators, or other providers as appropriate. CTCs also plan and participate in early intervention public awareness efforts, provide consultation to families and providers, conduct outreach activities outside the hospital, and serve on hospital- and community-based committees and special projects related to special needs children and their families.

Other Services

The CSHS program maintains affiliations with:

- Carolina Children's Communicative Disorders Program based at the Otolaryngology/Head and Neck Surgery Division at UNC Hospitals. This program serves children with severe hearing loss and other communication disorders, often through the use of cochlear implant devices. During the past seven years, almost 700 children have been served through this program, with an average of eight approvals per month.
- The UNC Craniofacial Center provides a wide array of services to children born with a craniofacial deformity generally requiring extensive, long-term treatment. Last year 357 children were evaluated at the program.

Direct Services: Other Populations

Reproductive Age Women

In FY 98-99, the North Carolina statewide Family Planning program provided services to 133,963 persons with a combination of Title X, Title V, Social Services Block Grant, Medicaid, State and local funding. Services were provided through contracts with local health departments (primarily) and other organizations under the same contract that governs provision of prenatal and child health services. Local health departments may transfer Title V resources among these programs to address changing local needs.

In FY 98-99, the high proportion of Medicaid recipients in prenatal clinics and the availability of higher Medicaid reimbursement levels contributed to a pattern of local agency transfer of funding from Maternal Health program budgets to their Family Planning program budgets. These local reallocations have enhanced statewide capacity to provide reproductive health services to low income women and men, and substantially contributing to efforts to reduce incidence of high-risk pregnancies and to assure optimal pregnancy outcomes.

As is the case with the prenatal care program, the Division provides extensive consultation and technical assistance to local providers of women's preventive health services. The Central Office resources and the statewide network of regional nurse and social work consultants described in the prenatal care program description also provide consultation to the local providers of preventive health services. The same customer-driven training program referred to above assesses and attempts to address in an integrated fashion both maternal health and women's preventive health training needs.

Support for family planning services has also been realized through annual transfers of Temporary Assistance to Needy Families (TANF) funds from the Social Services Block Grant to family planning, and subsequent allocations of all of these funds to local programs. Each year since 1996-97, \$1.6 million in TANF funding has been allocated for the purpose of reducing out-of-wedlock births.

Enabling Services: Pregnant Women and Infants

State Performance Measure #2: Percent of counties covered by standardized fetal and infant mortality reviews.

Four Fetal and Infant Mortality Review (FIMR) projects, covering 18 of the state's 100 counties, were funded in FY 98-99. Three were received Title V Block Grant funds: Carolinas Medical Center/Mecklenburg County (covering Mecklenburg, Union, Gaston, and Cabarrus counties), Wake Forest University School of Medicine (Forsyth, Davie, Davidson, Stokes, Surry, and Yadkin counties), and Wake County Human Services (Wake County). The remaining FIMR project is supported by a Healthy Start Baby Love Plus Eastern Region contract with the Pitt County Health Department in collaboration with East Carolina University Department of Obstetrics and Gynecology for Pitt, Bertie, Edgecombe, Green, Martin, Tyrrell, and Washington counties.

Additional WCHS Enabling Services for Pregnant Women and Infants

The Women's and Children's Health Section supports a wide range of enabling services with the goal of institutionalizing a coordinated system of support services which will provide families with the intensity and type of support services which best meet their needs and desires. Overcoming obstacles to

achieve this integrated, needs-driven system is an on-going process. WCHS continues to support the providers of support services through extensive training opportunities for new and established support service staff, ongoing consultation and technical assistance, and funding to hire additional support service staff.

Maternity Care Coordination

Maternity Care Coordination (MCC) is the cornerstone of the state's attempts to eliminate barriers to service provision. MCC services are provided by a nurse or a social worker whose primary role is to help clients access and effectively utilize services that address medical, nutritional, psychosocial and resource needs, while providing emotional support. The majority of MCCs are based in local health departments, but an increasing number are being based in private prenatal provider offices.

WCHS provides start-up funding to local providers of support services to encourage them to hire additional care coordinators in order to increase the percentage of Medicaid clients who receive care coordination. WCHS also administers a limited amount of state appropriations which categorically support the provision of care coordination services to clients ineligible for Medicaid. Local health departments are free to allocate portions of the block granted federal and state funds they receive to provide MCC or other support services to clients ineligible for Medicaid.

WCHS provided support services to 55,492 women in FY 98-99. The majority of these services were provided during the 219,080 MCC visits recorded that year. Approximately 43% of Medicaid-eligible pregnant women received MCC services in FY 98-99.

Maternal Outreach Worker Program

The Maternal Outreach Worker (MOW) program grew out of the state's experience with the MCC program. MCCs, who are trained professionals working primarily in clinic settings, had only limited time to address the social and emotional support needs of many of their clients. It was felt there was a need for community-based services provided by women with strong community roots. MOWs are paid, trained paraprofessionals who work under the supervision of an MCC and function in some respects as an MCC-extender. The MOW functions as a problem solver, assessing each client's needs and working with the client to address those needs, adopt healthy behaviors, and avoid unintended pregnancies postpartum. In FY 98-99, 26,335 MOW visits were provided to 4888 clients in 66 counties.

By 1996-97, evidence was emerging that MCC was no longer as cost-effective as it had been at its inception. The difficulty of maintaining a statewide cadre of trained MCCs and MOWs in the face of a

moderately high degree of turnover at the local level was apparent. The wide variation from one health department to another in the content of MCC and MOW encounters also raised concerns. The Medicaid reimbursement methodology, which reimburses health departments for a month of service, regardless of the intensity or complexity of the client's needs, seemed to be encouraging a "one size fits all" approach to maternity care coordination. Many agencies were also creating unrealistic caseloads for MCCs and MOWs, in some instances because of an inability to expand staff and in other instances in an effort to maximize revenues. Whatever the cause, excessive caseloads inevitably led to a deterioration in the quality of the service provided and to a decrease in the effectiveness of the interventions. Preliminary planning to address these emerging issues began in FY96-97 and continued in FY 98-99.

Infant Mortality Reduction Programs

The Minority Infant Mortality Reduction Program (MIMRP) represents North Carolina's most closely focused attempt to reduce the 2-fold disparity in white and minority infant mortality in the state. MIMRP funds 15 projects across the state which are charged to demonstrate community-based, consumer-driven interventions which will reduce infant mortality among the African American, Hispanic, and Native American communities. During FY 98-99 the MIMR Program provided planning grants to fifteen community based organizations. Following the planning grant process, five projects were awarded Minority Infant Mortality Reduction Fund for 2½ years. Ten of the original projects were also refunded for an additional three years. Selection criteria included ability to demonstrate deep roots in a minority community, strong credibility within that community, and a good track record of achievement. Working closely with North Carolina's Office of Minority Health, the Section has provided these agencies with extensive consultation and technical support. In FY 98-99 two skills-building workshops were held for the project participants which included training on effective evaluation strategies and fiscal accountability, as well as other subjects.

Most of the efforts of the MIMRP grantees have focused on enabling services. A number of the grantees provide lay helpers to clients. Some provide mentoring activities and preconceptional health information as well as continuing education and support for program participants. Many have taken on an ombudsman and advocacy role for their clients within the public health and social service systems. Almost all mediate between clients and existing human services agencies in the community to eliminate barriers to care and to promote culturally competent and sensitive care. All of them try to build bridges between their communities and existing human services providers. MIMRP was conceived as primarily a demonstration project, so the numbers of persons served by the program may not be great enough to impact statewide performance measures.

The Targeted Infant Mortality Reduction (TIMR) program was established by the General Assembly in 1989 to provide funding that would improve the perinatal care systems in high “attributable risk” counties in the state (i.e., counties with high numbers and rates of infant mortality). Although recipient counties have substantial flexibility in the use of these funds, most of the \$306,000 annual appropriation is used to support enabling services. Counties have expanded outreach efforts in maternity and family planning clinics, provided transportation and child care services for clients, and provided enhanced follow-up of persons with positive pregnancy tests and missed prenatal care appointments.

During FY97-98, the Section received the first year of funding for the federal Healthy Start grant, Healthy Start Eastern Baby Love Plus. The goals of this project are to reduce infant morbidity and mortality in the seven county project area in eastern North Carolina by incorporating three models to: support and empower a community-based consortium; provide outreach and case finding services; and to provide facilitating services which will reduce barriers to accessing services.

This project is presently in its third year of funding and has demonstrated effectiveness through its intensive outreach and facilitating services efforts. During FY 98-99, facility services were provided to over 2200 families. The Community Health Advocates provided over 20,000 outreach contacts. Consumer representation has risen to over 35% of the regional consortium make-up. The annual Healthy Start Training Institute continues to grow with over 400 consumers, health and human service providers, and other community members in attendance during the 1999 event. The regional consortium provided community subcontracts to community-based organizations to also develop local programming to address infant mortality and morbidity in their community.

Enabling Services: Children (and children with special health care needs)

National Performance Measure #3: Percent of Children with Special Health Care Needs (CSHCN) in the state who have a “medical/health home.”

The first step toward assuring that a child has a medical home is to ensure adequate health insurance coverage. For children with special health care needs, having insurance that covers a good benefits package - inclusive of preventive, specialty care and enabling services – is a critical factor in establishing a medical home. While there have been expansions in Medicaid, there were an estimated 131,000 children with family incomes below 200% FPL uninsured in North Carolina prior to the implementation of CHIP.

During FY 98-99, an overarching focus of the CSHCN program in North Carolina was implementation of *Health Choice*, the child health insurance program. In particular, staff and advocates directed energies towards development of the specific legislative provisions for children with special health care needs and the establishment of the NC Commission on Children with Special Health Care Needs. The integrated programmatic approach adopted in North Carolina for Medicaid and CHIP allowed our state to create positive change for children insured in both publicly sponsored programs.

Beyond providing a child with an insurance card, designation of a primary care provider is a second critical step in establishment of a medical home. On this front, there are significant differences between Medicaid (Health Check) and CHIP (Health Choice). Health Check is essentially a managed care program with every child linked to a primary care provider/medical home at the point of enrollment or re-enrollment. This approach, referred to as Carolina ACCESS, began as a demonstration program and was implemented statewide in 1998. While this does not assure the level of coordination associated with the federal definition of a medical home (especially for CSHCN), it does serve as an important structural element in building a system of care for Medicaid eligible children.

In contrast, Health Choice is a fee-for-service open indemnity program. Enrollees are free to choose any provider willing to accept Health Choice (BC/BS). No legislative provisions were made for establishing a medical home. This has served as a challenge in assuring that Health Choice enrollees are linked to a primary care provider who can serve as a child's medical home. The hope is that this issue will be addressed, in part in the future, by creating a prospective identification process for CSHCN, strengthening benefits education, and implementation of the care coordination benefit available to Health Choice enrolled children with special needs.

It is important to note, though, that the federal definition of medical home goes beyond identifying a consistent primary care provider willing to coordinate the delivery of services for a child. It describes characteristics of the relationship between the provider and family and considerations regarding the process for identifying needs and resources and developing and delivering a plan of care.

In this context, the CSHCN Program, in partnership with the Division of Medical Assistance, has worked for a number of years to improve the quality of services and to implement appropriate service delivery patterns of care to CSHCN in North Carolina. One example of how these activities can promote and support the concept of a medical/health home was the development of guidelines to approve and purchase pediatric mobility systems for CSHCN. These guidelines, developed jointly by Medicaid and the Children's Special Health Services (CSHS) Program, have resulted in the involvement of both the primary

care physician and the specialty care physician in prescribing appropriate systems. This team approach also includes other health care providers and families in decision-making roles. Moreover, it requires that all members of the team be identified in the letter of medical necessity and that primary care or specialty care physicians sign the authorization request for purchasing services. This procedure has enabled all parties to become more involved in reviewing the medical, cognitive, and community needs of the child and family. CSHS is responsible for quality assurance and Medicaid is responsible for funding pediatric mobility systems through this process.

State Performance Measure #1: Number of cases of substantiated child abuse and neglect

During FY 98-99 over 300 participants completed the “Empowerment Skills for Family Workers” training offered by the NC Family Resource Coalition. These participants included front line workers from a broad range of public and private non-profit agencies serving families in North Carolina as well as some family members. In addition to increasing competencies related to family support, this training has also strengthened interagency coordination and collaboration in many communities across the state.

Representatives of Women’s and Children’s Health Section participated with a variety of other public and private non-profit agencies and organizations in policy development and service planning related to supporting families and thus reducing incidents of child abuse and neglect. These included: NC Division of Social Services; NC Partnership for Children; Prevent Child Abuse NC; Family Support Network; Office of Juvenile Justice; Child Fatality Task Force; and others.

Seven pilot projects of the Intensive Home Visiting (IHV) Initiative were established during FY 98-99, and another seven counties were awarded grants to initiate IHV projects in their communities. This Initiative utilizes state funds to expand the range of existing home visiting programs available to families in order to improve various health and social outcomes. A primary focus of IHV is to reduce morbidity and mortality resulting from child maltreatment through primary prevention. Through the IHV Initiative communities may receive funding for implementation of one of three national home visiting models that have demonstrated positive outcomes for families: *Pregnancy and Early Childhood Nurse Home Visitation* (David Olds model); *Linkages for Prevention* (a modified/ augmented version of the Olds model); or *Healthy Families America* (developed by the National Committee to Prevent Child Abuse). The initiative includes a program quality improvement component to assure that NC will experience results similar to those found in national research, reducing severity and frequency of child maltreatment.

Additional WCHS Enabling Services for Children

Child Service Coordination

The focus of the Child Service Coordination (CSC) Program is assuring access to resources in response to the identified strengths and needs of enrolled children and their families. CSC services are an entitlement for children eligible under the Individuals with Disabilities Education Act (IDEA). WCHS supports provision of high quality services through quarterly support meetings, close monitoring of caseload sizes, supervisor training and support, and skill building sessions that are offered at least once a year.

Enabling Services: Other Populations

Women Of Reproductive Age

The Women's and Children's Health Section administers the Adolescent Pregnancy Prevention Program (APPP), a statewide initiative which provides support to community-based demonstration projects which design and implement interventions intended to reduce unintended pregnancies among teens.

In FY 98-99, 24 projects received support from an annual APPP budget of \$1.2 million. These projects provide a variety of programs, including abstinence and life skills education, youth development programs, parent workshops, counseling and referral, community awareness efforts, male involvement projects, and support services for teen parents. Projects that are most likely to be funded are those with strong collaborative ties to other community agencies and projects using "best practice models"---models of teen pregnancy prevention that have been evaluated and shown to be effective. Projects are located in many different types of agencies, such as health departments, schools and universities, local councils on adolescent health, adolescent health clinics, and other non-profit agencies.

Projects are evaluated each year by an independent evaluator, and although the number of teens served by any one project is typically too small for results to demonstrate statistical significance, a number of the local initiatives have shown impressive success in reducing the incidence of adolescent pregnancies among program participants.

The program began by funding demonstration projects, but the current focus is replication of teen pregnancy prevention strategies that have been evaluated and shown to be effective. Program staff provide focused guidance to prospective applicants and currently funded projects concerning the planning and implementing of programs based on interventions shown to be successful.

In FY 98-99 the Adolescent Parenting Program (APP) was transferred from the Division of Social Services to the Division. Although their names, and particularly their acronyms, are very similar, the programs differ from one another in several important respects. APP is targeted solely to pregnant and parenting teens while APPP focuses primarily on single teens. APP is substantially supported by Medicaid receipts, while APPP is funded wholly by federal and state appropriations and local support. Unlike APPP, all of the APP projects use a single intervention model, probably best described as a youth development/mentoring model. While the two programs are both intended to reduce unintended pregnancies among teens, APP is also focused on promoting parenting skills and preventing child abuse and neglect.

Population-Based Services: Pregnant Women and Infants

National Performance Measure #6: Birth Rate For Teens Ages 15-17.

Teen birth rates in North Carolina have declined steadily for the past several years. The 1998 teen birth rate (ages 15-19) was 62.8 per 1000 – the lowest rate for this age group in 20 years. Similarly, birth rates for 15-17 year olds decreased from 44.5 per 1000 in FY 96 to 39.1 per 1000 in FY 99. However, data from the most recent Youth Risk Behavior Survey (1997), indicate that teens continue to exhibit behaviors that put them at high risk for unintended pregnancies.

Funding levels are still insufficient to provide publicly subsidized family planning services to all teens in need. North Carolina, like many other states, in addition, because there is a great deal of popular sentiment that teens should not be sexually active, there are many barriers to maximizing the accessibility of contraceptives to teens. During FY 98-99, we have maintained existing services and made substantial progress in gaining approval for a Medicaid waiver to expand eligibility for family planning services.

National Performance Measure #9: Percentage of mothers who breastfeed their infants at hospital discharge.

In FY 98-99, seven percent (7%) more women who participated in the NC WIC Program during pregnancy initiated breastfeeding than in FY 97-98.

Three times a year, WCHS co-sponsors the North Carolina Lactation Educator Training Program with the Forsyth Memorial Hospital (Winston-Salem), the Northwest AHEC (an affiliate of Bowman Gray School of Medicine of Wake Forest University). This comprehensive seven-day program trains health

professionals in the necessary skills for dealing with common breastfeeding concerns and problems. A total of 70 health professionals completed the course in FY 98-99.

During FY 98-99, the effectiveness of the course was also evaluated by surveying students who were enrolled in the course. The study findings, which showed the course to be very effective for providing necessary skills and confidence to health professionals about breastfeeding, were reported to the faculty and WCH staff.

FY 98-99 represented the first full year that breastfeeding data was collected through the NC Pregnancy Risk Assessment Monitoring System (PRAMS). A March 1999 report from this population based data system showed that 59% of women initiated breastfeeding with 30% still breastfeeding 3-5 months after the birth of their baby. Breastfeeding Peer Counselor Programs continue to provide support to breastfeeding mothers and babies. Approximately 66% of the counties have breastfeeding peer counselor programs, an increase from 50% in FY 97-98. Many of the programs are operated in collaboration with the NC Cooperative Extension Service and community hospitals. A number of counties have obtained grant funds from associations including March of Dimes, Smart Start, NC Nutrition Network, and Kate B. Reynolds to expand and enhance support of their breastfeeding support programs.

State Performance Measure #5: Percent of women who gained greater than 15 pounds during pregnancy.

Although moderate, NC has seen an increase over the last three years (83.5% to 85%) in the percentage of women who gained more than 15 pounds during pregnancy. Efforts continued to assure that every woman who attends prenatal care offered through the public health departments and/or who receives WIC Program services has her weight gain monitored and is counseled on the importance of gaining adequate weight during pregnancy.

Additional Comments

Since 1990, the Section has participated in a public/private partnership to conduct an award-winning statewide public education campaign (*First Step*) and toll-free hotline (*1-800-FOR-BABY*). In FY 98-99, a partnership of agencies decided to pool resources and create a new service called the North Carolina Family Health Resource Line which incorporates the First Step campaign along with other state child and family programs. The 1-800-FOR-BABY number and marketing continue. The NC Family Health Resource Line uses the toll-free number, but advertises it using the numeric format (1-800-367-2229).

The First Step campaign uses a multimedia approach to focus public attention on the importance of preconceptional health, prenatal care and appropriate parenting skills. Callers to the hotline receive information on healthy pregnancies and a variety of other topics such as domestic violence, substance abuse prevention and treatment, parenting, housing, transportation, car seat rentals, public assistance, and other local resources. The hotline employs bilingual staff, has a TTY line to support the deaf and hard of hearing, and employs a substance abuse specialist to address the needs of substance using callers and providers with questions or concerns relating to substance abuse. In FY 98-99, 34,115 calls were answered by the hotline.

In FY 98-99, the Minority Infant Mortality Reduction Public Awareness Campaign was continued. This multimedia effort focused specifically on African-American families and included the distribution of posters, a "family album" (an educational book which includes information on how to take care of yourself before and during pregnancy and things to do as a new parent), television public service announcements, paid radio advertisements and a videotape with discussion guide for use in local communities. The theme of the initiative, "*Your Family is Bigger Than You Think,*" emphasized the positive message of the need for and availability of family and community support in achieving a healthy birth outcome. The initiative was the recipient of an award from the national Healthy Mothers, Healthy Babies Coalition in 1997.

One additional educational campaign -- the "Marta Campaign" -- was initiated in FY 98-99. The goal of this campaign is to help link the Latino population to existing women's and children's health resources. It is hoped that Marta, the fictional character featured in campaign materials, will be used in future campaigns, thereby creating a trusted advisor that people can look to for answers to health questions. Educational materials including a brochure and calendar were developed in Spanish describing how to enroll in Medicaid, the Child Health Insurance Program (Health Choice), and daycare centers. These materials were distributed at community health centers and local *tiendas* or convenience stores. A database of agencies which serve a high Latino population was developed and these agencies received several targeted mailings of materials.

The Section is the home of the North Carolina SIDS Program, which has traditionally provided grief counseling and information to families anywhere in the State following the loss of an infant due to Sudden Infant Death Syndrome. Grief counseling services are provided by either a local or regional SIDS Counselor. The SIDS Program also provides training and information about SIDS to community groups, professionals and first responders. In FY 98-99 counseling was provided to 49 families or 50% of all SIDS families.

During FY 98-99, the SIDS Program continued to expand its efforts to support primary prevention of SIDS deaths by promoting public awareness of the importance of proper infant sleep positioning. The State campaign was designed to complement the national “Back to Sleep” (BTS) campaign by ensuring access to national public education materials through the hotline and other local sources. A *photo-novella* targeting African American multigenerational families was developed and distributed. It has received very positive reviews and continues to be frequently requested for use in the community.

During FY 98-99, WCH continued to work with the March of Dimes (MOD) and the NC Neural Tube Defects Prevention Task Force to support activities to increase folic acid consumption. A major accomplishment was infrastructure development. The March of Dimes has been designated the lead agency in North Carolina for activity around folic acid, and also co-chairs the Task Force. In 1999, the NC Chapters of the MOD received from the National March of Dimes a three-year grant award, which will enable continued collaboration. This fiscal year also saw expansion of the Birth Defects Monitoring Program as the State Center for Health Statistics received a grant from the Centers for Disease Control and Prevention.

Population-Based Services: Children (and children with special health care needs)

National Performance Measure #4: Percent of newborns with at least one screening for PKU, hypothyroidism, galactosemia, and hemoglobinopathies

Universal newborn screening services have been available in North Carolina since 1966. In 1991, provision of such services became a legislative mandate with the passage of House Bill 890 “An Act to Establish a Newborn Screening Program Within the Department of Environment, Health and Natural Resources.”

The State Public Health Laboratory screens all newborns born in North Carolina for phenylketonuria (PKU), congenital hypothyroidism (CH), galactosemia, congenital adrenal hyperplasia (CAH), and hemoglobinopathy disease (e.g., sickle cell). Beginning in July 1997, screening for an array of metabolic disorders using tandem mass spectrometry technology was instituted. Timely follow-up is provided by the Genetic Health Care Newborn Screening Program on all infants with suspicious laboratory results.

Dependent upon the child’s diagnosis, various services are provided by medical centers. The University of North Carolina Genetics Program provides treatment and follow-up of all infants with PKU, galactosemia, and other metabolic disorders identified through tandem mass spectrometry. Special formulas are provided through the WIC Program and coordinated through a nutritionist in the Children and

Youth Section. Medical consultation and follow-up on infants with any of the disorders identified by the newborn screening program is provided through Duke University (Durham), University of North Carolina (Chapel Hill), East Carolina University (Greenville), Wake Forest University School of Medicine (Winston-Salem), the Fullerton Genetics Center (Asheville), and Carolinas Medical Center (Charlotte). In addition, children (and adults) with sickle cell disease may receive case management services from community-based sickle cell projects and regional sickle cell educator/counselors. Regional public health genetic counselors coordinate the genetic services component at the local community level.

National Performance Measure #5: Percent of children through age 2 with a completed immunization series.

The 1999 National Immunization Survey results revealed that approximately 84% of children in the target age group were fully immunized. North Carolina ranks 11th in the nation in childhood immunization coverage, and compares favorably with the national average of 80.6%. This indicator has steadily improved, although not significantly, since the implementation of the Universal Childhood Vaccine Distribution Program, and with the continued commitment of public and private providers. The Universal Childhood Vaccine Distribution Program (UCVDP) has allowed children to stay in their medical home by making vaccines more affordable. According to a study by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, before the UCVDP was implemented, 93% of North Carolina's doctors referred at least some of their patients to local health departments for immunizations and more than half referred up to 25% of their patients. Concerns regarding parents' ability to pay for immunizations constituted the most important reason for referrals. Since the inception of the UCVDP, North Carolina has experienced a return to the medical home for immunizations. The percent of children's immunizations provided by medical care providers outside of public health clinics has increased by 30 to 40 percent to an estimated 70%. North Carolina has shown the greatest increase among nine Southern states in returning children to their medical home for immunizations instead of to health department clinics.

Immunizing North Carolina's children has become substantially more complicated, and this trend is likely to continue. Changing schedules, new vaccines, state-provided vaccines, vaccine inventory, VFC eligibility and establishing and maintaining provider access to accurate immunization records are all significant clinical and administrative challenges to providing childhood vaccines. Nationally, immunization registries are emerging as critical tools for providers, public health and families working together to ensure high coverage rates. While North Carolina does have a registry implemented in the public sector, the current system is not flexible enough or robust enough to accommodate neither all

immunization providers nor the functionality necessary. To be truly effective, this approach requires universal participation and must be population-based.

One of the North Carolina Immunization Branch's chief priorities is to identify and purchase an existing immunization registry from another state for implementation in both public and private sectors in North Carolina. The new North Carolina Immunization Registry (NCIR) will become an integral part of the current state vaccine program, the Universal Childhood Vaccine Distribution Program (UCVDP). Providers will account for vaccine and manage inventories through this computerized system. The NCIR will assist healthcare providers and parents in assuring that all children are age-appropriately immunized, and allow public health providers to concentrate efforts on areas with a specific need for immunization improvement.

Through collaboration with the North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA) the Immunization Branch is actively participating in a unique demonstration project that will give providers secure Internet access to view immunization records. The Provider Access to Immunization Registry Securely (**PAiRS**) project was introduced to selected participants in February 2000. **PAiRS** links immunization records from both public and private sources in a database accessible through secure Internet connections. In an era of fragmented health care, **PAiRS** gives providers timely and efficient access to more complete immunization records for their patients, thereby helping to ensure that more children are immunized accurately and on time. A long-term goal of the project is to help facilitate the enhancement and full implementation of the North Carolina Immunization Registry (NCIR) in private immunization providers' offices statewide. This project will help to prepare providers, as it offers the opportunity to uncover and eliminate potential barriers and to clarify how an immunization registry can be successfully integrated within immunization service delivery.

National Performance Measure #7: Percent of fifth grade children who have received protective sealants on at least one permanent molar tooth.

During FY 98-99, coalitions of dental professionals and community partners worked in all 100 counties to promote and place dental sealants free-of-charge. A total of 25,353 or 31% of third grade children received protective sealants on at least one permanent molar tooth.

National Performance Measure #8: The rate of deaths to children aged 1-14 years caused by motor vehicle crashes.

In FY 98-99 the rate of deaths due to motor vehicle crashes for children ages one to 14 years was 5.4 per 100,000. Local Child Fatality Prevention Teams reviewed all deaths of children ages one to 14

caused by motor vehicle crashes. Local Team reviews have resulted in motor vehicle child restraint awareness campaigns and safety seat distribution programs in many counties.

National Performance Measure #10: Percent of newborns screened for hearing impairment at hospital discharge.

During calendar year 1998, 40 birthing hospitals received NATUS (ALGO 2e) AABR hearing screening devices. Approximately 15 of these hospitals started performing universal hearing screenings in the last quarter of calendar year 1998.

Percent of children ages 6 months to 6 years with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead.

During FY99, 98,359 children ages six months to six years were screened for elevated blood lead levels (2,686 children had a screening test greater than or equal to 10 ug/dL). Screening by private medical providers, including community and rural health centers, exceeded screenings conducted by local health departments. The number of children screened through local health departments has remained relatively constant, about 40,000 annually, for the past seven years (1994 – 1999). In contrast, testing through private clinics has soared since the State Laboratory of Public Health began offering blood lead analysis at no charge in 1994.

- In 1998-99, the State Health Director issued guidelines for lead screening and follow-up which changed the action level for educational follow-up and re-screening (diagnostic testing) to 10 ug/dL. Work began on collaboration with WIC clinics to assure that children not screened in their homes would receive lead screening during WIC visits.
- A targeted screening approach was adopted in local health departments, focusing on children at highest statistical risk for elevated blood lead levels, based on policies promoted by the CDC. The net effect of the targeted screening was nearly universal screening of children 12 and 24 months of age attending local health department well child clinics.

State Performance Measure #6: Percent of children aged 5-18 years who are obese (BMI ³ 95th percentile).

The following activities were completed during FY 98-99:

- Completed and distributed a major revision of the BodyWorks Weight Management Program. The revision included the addition of a chapter on follow-up to the group intervention and a series of seven newsletters – *The BodyWorks Connection*.

- Sponsored a 2-day interdisciplinary training on assessment and treatment of child and adolescent obesity. Seventy clinicians from the public and private sectors attended.
- Provided intensive training to school-based health center staff on the implementation of the BodyWorks Weight Management Program. This training added six additional teams of mental health and nutrition professionals to the BodyWorks provider list. A total of 20 NC school-based health centers now have BodyWorks providers on staff.
- Conducted a preliminary evaluation of the parent component of the BodyWorks Program. While this evaluation was small, it indicates that parents who participate in BodyWorks find the program to be worthwhile and perceive significant changes in their teen's communication skills and lifestyle behaviors.
- Provided training on pediatric nutrition including clinical management and community health promotion for 55 public health nutritionists.
- Analyzed data on the prevalence of overweight in school-age children for the Institute of Medicine 1998 Child Health Report Card.
- Awarded \$40,000 in mini-grants in collaboration with the NC Nutrition Education and Training Program to support nutrition education activities focusing on healthful eating to 14 school districts.

Population-Based Services: Other Populations

Women of Reproductive Age

In FY97-98, at the direction of the North Carolina General Assembly, WCHS transferred \$1.1 million in federal abstinence education funding to the Department of Public Instruction to support abstinence-only activities in North Carolina schools. Continued funding is anticipated for FY 00-01. WCHS staff work in collaboration with the state Department of Public Instruction to implement this program.

Capacity-Building/Infrastructure Services: Pregnant Women and Infants

National Performance Measure #16: Percent of very low birthweight births.

The percentage of very low birthweight (VLBW) births has been slowly increasing in North Carolina and in the nation as a whole, and no one really knows why. All the efforts focused on reducing the incidence of preterm birth (PTB) have not succeeded in reducing, on a population basis, the very high rates of preterm births we experience. Some care coordination and social support programs, including North Carolina's Baby Love program, have shown some impact on program participants, but overall the

rates of VLBW and PTB have not diminished. Moreover, VLBW/PTB contributes substantially to racial disparities in infant mortality: the black:white gap of 2:1 in low birthweight births widens to 2.5:1 for VLBW births, and to 3:1 for extremely low birthweight babies. The majority of the gap in mortality between black and white infants is accounted for by VLBW/PTB mortality.

WCHS continues to support a wide range of social support services, including Baby Love and related programs so that at-risk women in the state have maximum access to those non-medical services which may help to address this problem.

National Performance Measure #17: Percent of very low birthweight births delivered at facilities for high-risk deliveries and neonates.

A concerted effort at regionalization was made in the 1980's, and the system has worked fairly well, allowing the state to maintain the percent of very low birthweight births delivered at facilities for high-risk deliveries and neonates at about 80% since 1995.

The Neonatal Bed Locator Service has helped ensure that the system works efficiently, and many of the educational services the Section offers, particularly those carried out by the Perinatal Outreach and Education Program, emphasize to providers the importance of risk-appropriate intrapartum care and the improved outcomes associated with transfer of the high risk mother rather than the high risk neonate.

At the present time, concerns for the well-being of the regionalized system focus on the possible impact of managed care provider networks and the proliferation of nurseries caring for relatively high risk infants without the full resources of the tertiary centers.

National Performance Measure #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

North Carolina has maintained the percent of women who receive prenatal care in their first trimester at about 82% for the last five years. This statistic is has improved substantially since the late 1980, due to the expansion in Medicaid eligibility to 185% of the federal poverty level and the availability of presumptive Medicaid eligibility, both of which occurred near the start of North Carolina's improvement in this measure. The hotline and the other public awareness initiatives carried out by the Section, including the Minority Infant Mortality Reduction public awareness campaign, have also played a role in encouraging women to initiate prenatal care early in their pregnancies. The ROCI program, which has helped maintain the availability of prenatal care in underserved areas, has probably contributed to an improvement in this indicator also. These programmatic activities were continued in FY 98-99.

State Performance Measure #9: Percent of women who smoke during pregnancy.

Although North Carolina has experienced a decline in the percent of women who smoke during pregnancy, rates remain above regional and national averages. The Section has selected this indicator for inclusion because of the very substantial impact that smoking has on birth outcomes and as a spur to future activities to reduce the prevalence of smoking. As evidenced by activities carried out in FY 98-99, the Section is very interested in building capacity within the State to provide smoking cessation services. The Section will evaluate the effectiveness of these activities and will continue to work toward the goal of the routine inclusion of effective smoking cessation counseling into health services for all women of reproductive age.

Additional WCHS Capacity-Building/Infrastructure Services for Pregnant Women and Infants

Based on recognition of the diverse needs of counties and the Section's desire to support local decision-making, local health departments are afforded a great degree flexibility in allocating resources. In return, local agencies must fully describe the activities that Section funding will support and the amounts they are allocating to each of these activities. These activities may range from direct service provision to low income clients ineligible for Medicaid (funding calculated at the Medicaid rate for the service) to enabling, population-based or capacity building activities. In addition, health department performance is evaluated on the basis of a mutually agreed-upon set of process and outcome measures.

In FY 98-99, the Section also continued its local health department monitoring efforts, which are focused on multidisciplinary site reviews which use detailed review instruments to assess policies and practices for compliance with standards delineated in the contract between the Section and the local agency. Out of compliance items were noted and compiled into monitoring reports which in turn generated corrective action plans and further technical assistance as indicated.

Internal discussion began in FY96-97 and continued in FY 98-99 on how the Section could move from a classical external Quality Assurance process to one which would more effectively promote an internalized Continuous Quality Improvement process within local agencies. In FY 98-99, the Section began tailoring the periodicity of site reviews to the success of the agency in meeting expected standards of policy and practice. Whereas before, each local health department had a monitoring visit every three years, beginning in FY 98-99, based on the outcome of the site visit, the periodicity between site visits could be between 3 to 6 years. Section consultants continue to provide technical assistance and consultation as needed during the interim years.

The Section has long recognized the great contribution which lifelong wellness makes to good birth outcomes. It is clear that the effects of a lifetime of poor nutrition, smoking, substance abuse, a sedentary lifestyle and other unhealthy behaviors cannot be erased by even the best and most timely prenatal care.

Office of Women's Health

In FY 97-98, the Section became the home of the state's new office of Women's Health (OWH), which is charged to plan and facilitate ways of improving women's health throughout the life cycle. As part of its strategic planning process, in FY 97-98 the office conducted focus groups, created a North Carolina Women's Health Report Card and held a three day Women's Health Summit which enlisted partners and identified objectives, strategies and action steps to promote women's health in North Carolina. During FY 98-99, the major focus of the OWH was on HIV/AIDS/STDs in women. A one-day Mini-Summit was held in the spring on the topic of HIV/AIDS/STDs entitled "Developing a Message for the New Millennium." Ten task forces were formed around different populations of women (e.g., adolescents, drug users, pregnant women). The work of these task forces was instrumental in preparation for the statewide HIV/AIDS conference held in December 1999, with the second day of that three-day conference highlighting women's issues.

Support for Local Health Department MCH Services

In order to comply with federal regulations, the Division of Public Health started preparation for local health departments' conversion of state created HCPC codes to CPT codes. The actual conversion is scheduled to take place on July 1, 2000. During 1999, local health department staff were trained regionally on how to prepare for implementing ICD9/CPT Code Reporting. Trainings have been scheduled for FY 99-00.

Training

Each year, the Women's Health Branch within WCHS surveys local health department training needs and carries out scores of training events that reach thousands of health department and non-health department staff. The Section also administered the Perinatal Education and Training (POET) Program, a statewide network of skilled nurses who provide a wide variety of educational and training services to perinatal health professionals. In FY 98-99, these highly skilled professionals carried out 478 training programs, and a total of 61,671 learning hours (hours of programming multiplied by participants in the program) were provided.

Another important training program supported by the Section in FY 98-99 was the Women's Health Training Collaborative Program. This program trained local health department nurses in the skills

needed to function as public health nurses in an expanded capacity in health department prenatal and family planning clinics. During FY 98-99, 51 nurses completed the enhanced role training.

Prenatal Smoking Cessation

In recognition of the substantial adverse impact of tobacco use on birth outcomes, the Section continued its efforts to support preconceptional and prenatal smoking cessation training for health care providers in local health departments during FY 98-99. This statewide training was implemented by the perinatal outreach educators located in 13 sites across the state. *The Guide for Counseling Women Who Smoke*, developed by the Women's Health Committee of the NC Tobacco Prevention and Control Branch in 1996, continued to be the curriculum of choice used to train providers. It is founded on the evidenced-based practice of providing a brief intervention to all women who use tobacco. They are counseled regarding their tobacco use at each clinic visit to the health department. During FY 98-99, smoking cessation training was provided to 217 health care providers through a series of seven training sessions.

The Guide for Counseling Women Who Smoke has been well received both statewide and nationally since its inception and was distributed free of charge. During FY 98-99, a national distribution method was set up in collaboration with the National Maternal and Child Health Clearinghouse. The guide, its companion video, *Counseling from the Heart: Techniques for Counseling Women Who Smoke*, and the self-help booklet entitled *If You Smoke and Are Pregnant* are now available for purchase out of state through the Clearinghouse for \$25 (including shipping). The Clearinghouse also markets these materials, all developed in North Carolina, on its website and by way of a brochure developed by the Section for this purpose.

The Section received a grant in FY 98-99 from the North Carolina March of Dimes to support the part-time position devoted to coordinating this program and the training efforts, and to begin a pilot program training providers in a managed care setting. A planning phase began, where information was gathered, meetings held with the Division of Medical Assistance (State Medicaid agency), and discussions started regarding arranging and funding the training of staff in managed care programs established for Medicaid clients.

The Women's Health Committee had a one-day retreat at the end of FY 98-99 to develop long-term goals. The three chosen goals are to 1) market the perinatal smoking cessation program, 2) develop a systems approach for health departments who have been trained to further institutionalize the program, and 3) revise the guide, updating the medical information and supplementing sections on diversity.

Perinatal Services

In FY 98-99, the Section continued to support the Neonatal Bed Locator Program, an excellent example of a systems approach to perinatal care. This program provides a statewide network to identify available neonatal intensive care beds on an urgent or emergency basis. It provides obstetrical providers who need to transfer a high risk pregnant woman or neonate a connection to the nearest available tertiary center slot. For a relatively modest investment, the program provides twenty-four hour per day/seven day per week networking and referral services. It is expected that its main impact is on maintaining North Carolina's high rate of very low birthweight babies born in tertiary centers. By doing so, it is also expected to have an impact on each of the outcome measures, particularly infant mortality, perinatal mortality and neonatal mortality.

In FY 98-99, the Section again participated in the statewide maternity mortality review process. The State Center for Health Statistics used both a Vital Statistics review and a birth file/death file match to generate a fairly comprehensive list of pregnancy-associated deaths. These deaths were then reviewed by a physician volunteer for further classification. Results for CY97 births were released in April 2000 and CY98 data is currently being compiled. Discussions continued concerning ways in which this information could be more widely disseminated and more actively utilized to reform systems or practices where appropriate. This activity most directly impacts the state-specific maternal mortality outcome measure. It also has some potential to impact the other birth outcome measures. If the process ultimately leads to some systems reforms, it could also impact a number of performance measures.

A last example of an important Section planning activity carried out during FY 98-99 is the work of the Support Services Improvement Team, which planned for changes in the way support services would be delivered in North Carolina. Some of the issues they addressed were discussed in the enabling services section of this report.

In January 1999, the Maternal Health Unit of the Women's Health Branch held the "1999 Perinatal Health Models of Excellence Forum" to highlight programs employing a fresh approach to the problem of poor maternal and infant health outcomes. During the day-long forum, workshops were held by the three Models of Excellence award winners and semi-finalists and funding opportunities to replicate these programs were identified. The three award winning projects included an infant mortality reduction public information campaign, development of a Bacterial Vaginosis clinical risk scoring system, and a grassroots community-based health center serving low-income pregnant women and their children. They were also awarded funds to help develop the *North Carolina Models of Excellence Project Replications Guide: Perinatal Health - Promoting Positive Pregnancies and Healthy Birth Outcomes 1999*. One-time funding

was awarded to three local health departments for replication projects. There is some consideration to further develop a Models of Excellence program for the Section.

Capacity Building at the Community Level

In FY 98-99, the Section continued a number of efforts which promoted community development. The Minority Infant Mortality Reduction Program (MIMRP), which was discussed in the enabling section of this report, is an important community development effort for at least two reasons. First, the consultation and technical assistance provided to the community-based organizations in the program strengthens them, and this strengthens their communities. Second, the direct impact of these organizations, i.e., increasing skills among employees and clients, enhancing networking between human services agencies and communities of color and increasing the cultural sensitivity and responsiveness of these service agencies, strengthens their communities as well. The skills-building workshops conducted for project staff and the annual statewide conference serve to enable the projects to improve their infrastructures and their capacity to better serve their community.

The Section also administers another capacity building initiative, the Rural Obstetrical Care Incentive (ROCI) Program. ROCI provides funding to physicians and nurse-midwives providing obstetrical services which defrays a portion of the cost of malpractice insurance as an incentive to them to provide prenatal and intrapartum care in underserved areas to pregnant women, regardless of their ability to pay. In FY 98-99, ROCI funding was in excess of \$1.2 million, and approximately 11% of all deliveries in the state were performed by ROCI recipients. The Section also supports two information systems. The Health Services Information System (HSIS) is the core public health services data system in the state. Functioning also as a Medicaid billing system for local health departments, it provides reporting about all clinical and support services provided in health departments and demographic information about all clients served.

In FY96-97 North Carolina became a PRAMS (Pregnancy Risk Assessment Monitoring System) State. The Section continues to collaborate in this effort, which was led by the State Center for Health Statistics. These data collection efforts support sound policy development which may ultimately impact any of the performance and outcome measures relevant to pregnant women and infants.

The Healthy Start Eastern Baby Love Plus program also enhances community capacity-building by funding, training, and technical assistance to community-based organizations that implement local infant mortality reduction efforts in the seven-county region.

Capacity-Building/Infrastructure Services: Children

National Performance Measure #12: Percent of children without health insurance.

Data used to prepare the state's Child Health Insurance Plan (*Health Choice*) indicated that approximately 220,000 North Carolina children ages 0-18 years were uninsured. Approximately one-third were estimated to be eligible for Medicaid, but not enrolled. Another one-third were estimated to be eligible for *Health Choice*. By September 30, 1999, 56,840 (80%) of the estimated 71,000 children potentially eligible for *Health Choice* were enrolled. Likewise, the total number of Medicaid-eligible children increased by 1.24% between 1997 and 1999 (491,070 to 497,239). This trend was mostly influenced by an increase in the number of children eligible for Medicaid's SOBRA expansions covering Medically Indigent Children (49,482). During the same time period, the children on TANF decreased by 24,117. (North Carolina has revised its methodology for calculating numbers of insured and uninsured children. We were using the Current Population Survey (CPS) as the primary data source for these numbers. We abandoned the CPS as our primary data source because it:

- Grossly undercounts the number of children in the Medicaid program. The new methodology allows us to use actual Medicaid enrollment data.
- Did not include a question on whether children had coverage under NC's Health Choice program. Therefore, we used actual Health Choice enrollment data.
- Generated inaccurate numbers -- for example, according to the CPS there were 131,277 total children in the state who were under age 6 and had incomes at 100% of the federal poverty level or less. In fact, in the Medicaid program alone, there were 204,996 children in that same age and income bracket.

In addition, although our original estimate was based on 2-year averages of CPS data, when the CPS is used in our new methodology, three years are aggregated. HCFA uses three-year averages, and we think that is a more appropriate use of the data, given the very small number of sampled children in our state.)

Enrollment

Despite North Carolina's decision to implement a separate CHIP rather than a Medicaid expansion, the decision was made to do outreach and enrollment of families in a seamless process. A range of activities to enhance the enrollment process for both Medicaid and *Health Choice* have been implemented including a simplified 2-page application form, multiple community application sites, mail-in option, training of community professional and agency staff to assist with the application process, 12 months

continuous eligibility for both Programs, and availability of applications in English and Spanish. These changes enhanced the success of our outreach efforts.

Outreach

North Carolina decided to focus on a grassroots approach to outreach with our CHIP Program. We are a diverse state both racially and in relation to geographic/regional cultures. We are also a state with a tradition of strong local governance and autonomy. For all of these reasons and more, we felt grassroots, community-based approaches would work best. Therefore, each of our 100 counties, working through the co-sponsorship of health and social services departments, was asked to form an outreach coalition. Coalitions were asked to pull in a diverse group of individuals representing public and private NFP agencies, churches, businesses, schools/day cares, Smart Start, providers, media, consumers, and other child advocates. These coalitions have been very effective in crafting outreach strategies specific to the circumstances of their individual communities and target groups.

In a parallel fashion, WCHS convened a state level coalition called the Health Check-Health Choice Outreach Committee, comprised of state, regional and local representatives from public/private agencies, health care provider organizations/associations, and child advocates. Like the local coalitions it includes representation from diverse groups who could assist and guide us in our outreach efforts.

The WCHS role has been to support efforts of local coalitions by providing print materials, electronic media pieces, monthly updates, consultation/technical assistance, workshops, and targeted outreach to various groups/organizations from the state level. Health Check/Health Choice outreach efforts are provided by WCHS, Division of Social Services and other public and private-sector partners. For example:

- The NC Healthy Start Foundation was contracted to develop a program name, logo, print materials, electronic media pieces, conference exhibits, and statewide campaign strategies.
- An existing contract with the American Social Health Association to provide information and referrals to Health Check (EPSDT) was expanded to include information, referrals and advocacy for NC Health Choice. Callers may call this toll-free line and receive an application by mail.
- The NC Foundation for Alternative Health Programs, a foundation associated with the NC Office of Research, Demonstrations and Rural Health Development, agreed to contribute to our efforts by submitting a grant application to The Robert Wood Johnson Foundation for the Covering Kids Grant. As a result, we received funding for a demonstration project in Buncombe, Cabarrus,

Edgecombe, Forsyth and Guilford Counties. This initiative provides North Carolina with the opportunity to design and test approaches for reaching and enrolling children in pilot counties by targeting business, the provider community, the faith community, the Latino community, the African-American community, and by refining the enrollment and re-enrollment processes.

- Funding from the Duke Endowment has allowed us to fund six multi-county pilot projects that specifically target outreach to minority populations including African Americans, Hispanic/Latino, and Native Americans. The lesson learned is that, especially for these populations, a personal contact from an individual or agency with whom the family already has a high level of trust is the key to success.

The grassroots approach and partnering with other organizations and funders were critical elements to the success of outreach efforts. In FY 98-99, 69-70% of children came from below 150% of the federal poverty level. We attribute that to a number of factors. First, with 44% of the births in North Carolina paid for by Medicaid, we have a large number of customers satisfied with publicly-supported health insurance. Secondly, our first year outreach efforts featured a broad based general education campaign (e.g. fliers sent home with report cards to every school-age child in the state), as well as targeted outreach to those already enrolled in means-tested programs (e.g. subsidized day care, WIC, Head Start and other programs). Lastly, we benefited from aggressive targeting of Medicaid graduates and TANF drop-outs by local county social services offices. An estimated 69% of the enrollees learned the specifics about the insurance programs from county DSS offices.

We have been less successful in reaching out to those over 150% of the federal poverty level. Possible reasons for this include: enrollment fee (the leading cause for denial of applications was "failure to pay the enrollment fee"); required documentation of business records for last 12 months for self-employed applicants; and/or lack of specific efforts targeting the business community. During FY 98-99, planning and implementation of outreach targeted to business and higher income families was initiated. Glaxo-Wellcome Inc. is an important partner in this effort. Sales representatives working with the Caroliance, a private not-for-profit organization which provides a group insurance pool for small business employers, have been sharing Health Check / Health Choice as one insurance option as they meet with these employers and their employees.

Medical societies and professional associations have also played a vital role in the outreach effort by informing their membership about the new Child Health Insurance Program (via their statewide meetings and professional newsletters) and by serving on our Outreach Committee, the Commission on

Children with Special Health Care Needs and our Provider Task Force. The latter two groups have assisted the State with designing health benefits for children enrolled in CHIP.

Coordination and Planning:

The Division of Public Health, Women's and Children's Health Section continues to provide leadership to insure that all appropriate public and private health insurance programs, medical societies, professional associations, state and local agencies, child advocacy / non-profit organizations, business and faith community partners, and grant funding partners are involved in the ongoing planning and implementation associated with outreach for our publicly-funded child health insurance programs.

Initial Health Choice outreach activities targeted populations likely to be eligible for Health Choice including those enrolled in subsidized child care, WIC, Head Start and other programs. Also, for families whose incomes are $>150\%$ FPL and $\leq 200\%$ FPL, there are enrollment fees of \$50/child/year up to maximum of \$100/family/year which has been a deterrent. The highest rate of denials is for families who apply but fail to pay the enrollment fee. We cannot estimate how many families are deterred from ever applying due to the enrollment fee.

The Division has hired a staff member to spearhead outreach to minority populations. This individual will work with our Duke Endowment-Funded Minority Outreach Projects (six multi-county projects). She will also partner with minority leaders and organizations; minority-owned or highly minority attended private practices; minority-owned businesses; businesses who employ large numbers of minorities; and the faith community and their outreach ministries. This individual will provide technical assistance to local coalitions relating to minority outreach, sharing lessons learned from the Duke Endowment Projects. The position will also work with the development of marketing pieces in relation to minority outreach.

Complimentary outreach and benefits education materials targeting children with special needs have been developed and are being disseminated to a network of state and community stakeholders who work with these populations. In addition, technical assistance and consultation is being provided to local groups and pediatric provider systems regarding the importance of outreach and benefits education to these families. We continue to expand the capacity of both the Health Choice Special Needs Helpline and the NC Family Health Resource Line for providing information and referrals to these families.

National Performance Measure #13: Percent of potentially eligible children who have received at least one Medicaid service.

The major initiative planned to address the issue of children without health insurance was implementation of Title XXI. North Carolina approached Title XXI as an opportunity to enroll eligible children both in the Medicaid and the Children's Health Insurance Program (CHIP). Major activities included:

- **Eligibility and Enrollment:** A range of activities to improve the enrollment process for the Medicaid Program and to allow for a seamless enrollment procedure for Title XXI was developed and implemented, including: a shortened application form designed to be self-completed and mailed in by the potential recipient; extensive out stationing of eligibility workers; a continuous eligibility period of 12 months; and training of non-DSS community-based representatives to distribute applications at a wide variety of alternative locations.
- **Outreach and Utilization:** Development of a program name and identity through consumer focus group testing; emphasis on increased public awareness and education by expansion and integration of campaign function; development of county kits; and redefinition of Health Check Coordinator's roles.

The name "Health Choice" was chosen for North Carolina's CHIP Program and the decision was made to market Health Check (the state EPSDT program) and Health Choice together. This was the impetus for the creation of multiple complimentary planning decisions, public awareness strategies, and outreach approaches between the two programs. The informational effort also included development of a Resource Line, to provide all families and adolescents with a mechanism to receive answers to basic health questions and to provide a database of county-specific resource and referral information on health providers for children and families. The Health Check/Health Choice campaign office is housed with First Step and the NC Healthy Start Foundation. The Foundation developed an intensive marketing campaign to encourage broader awareness and full utilization of the health education benefits of this resource.

In FY 98-99, HCFA changed the annual reporting requirements for Medicaid recipients in an effort to obtain consistent and comparable data between States. These changes affected the way the participation rate is calculated. The following is a list of the significant changes: utilization of the periodicity schedule, precise definition of total population, data collection oriented by date of service, and specific CPT/HCPC and ICD-9 codes for reporting.

By using the previous calculation method, the participation rate for FY 98-99 increased from 54.8% to 57.2%. Using the revised calculation method, the participation rate for FY 98-99 is 66%, as compared to 63% during the previous fiscal year. Local Health Departments provided 50,807 Health

Check screenings to children and youth under 21 years of age. The following additional activities were also completed during FY 98-99.

- An 2-day annual conference was conducted for Managed Care Consultants and Health Check Coordinators.
- Consultants conducted regional meetings for Health Check Coordinators.
- Introductory Training Sessions were held for new Health Check Coordinators and Supervisors. Sessions were held on a quarterly basis.
- Fiscal and programmatic consultation was provided to counties seeking to use alternative funding sources to implement Health Check Outreach Projects.

National Performance Measure #15: The rate (per 100,000) of suicide deaths among youths ages 15-19.

A Youth Suicide Prevention Task Force was organized, led by the Chief Public Health Social Worker and the Injury and Violence Prevention Unit Manager. There is broad based representation on the Task Force, including public health, mental health, education and survivor/advocates. The Task Force has explored the suicide problem among youth in North Carolina and decided on a strategy that includes the development of a comprehensive state plan to address the problem and to develop resources to implement the plan.

Local Child Fatality Prevention Teams continue to review all suicide deaths of children, ages 1-19. These local reviews have resulted in an increased awareness of adolescent suicide and suicide prevention at the local level.

State Performance Measure #7: Percent of children in regulated child care settings that are served by a qualified child care health consultant.

The focus of the Healthy Child Care Initiative is enhancing health and safety in child care settings across North Carolina. Along with intensive outreach efforts for the NC Health Check and Health Choice Program (described previously), a marketing campaign will be used to encourage pediatricians and local health departments to provide health consultation to child care providers in their respective communities. Health and safety information is made available to child care providers through a Child Care Newsletter, a Child Care Health and Safety Calendar, brochures, resource materials and implementation of a Child Care Health Consultant Training Program.

The Healthy Child Care North Carolina Campaign recently joined with the Health Check hotline, and has hired (and co-located) an additional staff member trained in early childhood care. This expansion of the hotline service allows immediate response to question and issues raised by child care health consultants, as well as a more integrated system of public education, information and referral, and advocacy for families and service providers regarding the health, development and safety of children and youth.

Joint planning and collaboration has resulted in the successful development and maintenance of a broader and more responsive child service infrastructure. The ongoing involvement of key agencies, families, communities and providers has contributed to a successful blending of fiscal and personnel resources from participating agencies.

State Performance Measure #8: Percent of children and adolescents attending public schools with access to services of a school-based or school-linked health center.

At the end of FY98-99, there were 25 School-based/School-linked health centers screening adolescents in NC. These included projects receiving funds through the Robert Wood Johnson Foundation, and the Women's and Children's Health Section. These centers provided access to services for approximately 97,911, or 7.9% of students enrolled in North Carolina Public Schools (1,246,082). Those students with parental permission have access to a range of comprehensive services including prevention and the treatment of acute illness and injury; management of chronic illnesses; psychosocial assessment and supportive counseling; drug and alcohol counseling; immunizations; visual and dental screening, and nutrition counseling. These centers provide health care services to the entire range of students having access to these centers, including those with special health care needs and chronic illnesses.

State Performance Measure #10: Percent of counties with active Child Fatality Prevention Teams

Local Child Fatality Prevention Teams (CFPT) have documented local prevention action and changes since May 1994, including interagency communication regarding high-risk families, public education campaigns, advocacy for child safety in human service delivery, and dissemination of prevention materials. Each local team is composed of appointed members representing agencies such as the health department, department of social services, police department, medical examiner's office, guardian ad litem, district attorney's office, fire departments and other child advocacy organizations. In reviewing child fatalities, CFPTs:

- Identify the causes of child fatalities
- Identify ways to improve the delivery of services to child and families, and

- Make and carry out recommendations for change that could prevent future child fatalities.

The results of these reviews are shared with the N.C. Child Fatality Task Force, the state CFPT (administered by the Office of the Chief Medical Examiner) and other local CFPTs. Local Team recommendations have been the key to success in a number of important legislative and policy initiatives that include the: Graduated Drivers License law, mandated smoke detectors in rental property, seat belt laws, intensive home visiting, and gun control, among others.

Additional WCHS Capacity-Building/Infrastructure Services for Children

Childhood Asthma

Improving childhood asthma management and control is a top priority of the NC Department of Health and Human Services (DHHS). At the request of the state health director, the NC Childhood Asthma Initiative Task Force was convened in 1998 to assess the state of pediatric asthma and make recommendations for implementing a statewide effort to more effectively address this disease. The Task Force laid the groundwork for the recently established Asthma Alliance of North Carolina (AANC).

The AANC is a partnership of local and state government agencies, academic institutions, local asthma coalitions, non-profits and private industry. Its mission is to reduce asthma morbidity and mortality for all people in North Carolina through a comprehensive public health approach. AANC goals are to:

- Determine and monitor the prevalence, distribution and consequences of asthma on the health and well-being of North Carolinians;
- Ensure the appropriate diagnosis and management of asthma by health professionals;
- Identify, develop and promote effective environmental interventions;
- Increase public awareness and knowledge of asthma;
- Support and strengthen community-based asthma initiatives; and,
- Influence public policy, regulation and legislation.

The following committees have been established to develop and implement strategies to achieve these goals:

- Medical Management and Patient Education Committees. The AANC will continue its efforts to train and certify health professionals in asthma education, improve the quality of care for Medicaid enrollees, and raise awareness for asthma management among child care workers, teachers, school nurses, parents and patients.
- Epidemiology Committee. In the fall (2000), the AANC, in collaboration with its members, the Children and Youth Branch of the NC Division of Public Health (DPH) and the UNC School of

Public Health, will release the results of an asthma prevalence survey of 192,000 7th and 8th graders from public schools. This unique study, the Breathing Survey, will give DPH data on the extent of asthma in this population, barriers to care, and functional costs associated with this illness. It will provide a foundation from which a permanent asthma surveillance system can be built.

- **Environmental Committee.** Hundreds of Environmental Health Specialists (EHS) will be trained in ways to conduct an indoor air quality assessment. A system to link health care providers of children with asthma with home asthma inspectors is being tested, as is the effectiveness of low-cost environmental interventions in the home. The Alliance is also supporting the Division plan to study the asthma-related consequences of the floods born from Hurricane Floyd.
- **Public Relations/Marketing Committee.** The AANC intends to raise awareness for asthma issues by expanding the membership of the Alliance, increasing use of and access to the American Lung Association's educational programs, developing an asthma coalition resource guide, improving the Alliance's website, and implementing a conference on asthma-related issues.
- **Local Coalitions Committee.** The Children and Youth Branch hired an Asthma Program Coordinator to serve as the director of the Alliance and to help communities build local asthma coalitions and programs across the state. This Coordinator provides local coalitions technical assistance and resources, including linking asthma contacts and identifying best practices. Already more than 50 counties have an asthma project or coalition in place.
- **Advocacy/Legislative Committee.** The AANC plans to: address Medicaid and third party payer reimbursement for asthma education, work to secure a permanent funding stream for asthma efforts, review the categorization of peak flow meters and spacers as durable medical equipment (DME), collaborate with clean air and anti-tobacco organizations, and possibly explore the feasibility of reimbursement for low-cost environmental interventions.

School Health Services

Restrictive language prohibiting SBHCs from receiving reimbursement under Health Choice was not removed during the legislative session that ended in October 1998. By the next legislative session, the House majority had changed from Republican to Democratic, and new legislation, NC Senate Bill 26, CHIP Clinics/Repeal Prohibition was introduced. With support from the North Carolina Pediatric Society, the Covenant with North Carolina's Children, and the Secretary for Health and Human Services, the bill was passed in the House of Representatives on March 10, 1999, and signed on March 18, 1999.

Making The Grade in NC (MTG in NC) secured \$42,000 of one-time Maternal and Child Health block grant funds for school-based and school-linked health center planning grants in two categories, new (communities without an existing SB/SLHC), and expansion of existing services to meet the North Carolina Comprehensive School-Based /School-Linked Health Center (SB/SLHC) Model and credentialing. Awards were made to twelve centers in September.

Regional school nurse, nutrition, and social work consultants and central office MTG staff provided technical assistance to all school-linked and school-based centers in the state by phone and/or on-site visits. Technical assistance workshops were offered covering: Comprehensive Model, Credentialing, Needs and Assets Assessment, Strategies for Communication, Evaluation of Services, Financial Sustainability, Services/Site Selection and Staffing, and Building Diverse and Broad Community Support.

The Finance Committee in collaboration with the Clinical Consultant for Systems Development, worked with other MTG staff to develop a survey that addressed the successes and difficulties that centers had experienced trying to secure third party reimbursements. A phone survey of twenty-eight project directors representing 4 school-linked centers and 54 school-based centers was conducted. Lessons learned from the survey were incorporated into the committee's workplan for 1998-1999 which included: regional workshops on ICD-9/CPT Coding; a SB/SLHC financing workshop; and a manual on third party billing and financing.

A process for credentialing SBHCs was implemented this year. This was done in collaboration with the Division of Medical Assistance (DMA). so that centers could be exempted from obtaining PCP prior approval before delivering services to students enrolled in Carolina ACCESS (NC's Medicaid program). In February, "The Essential Characteristics for School-Based Health Centers Which Are Providing Services to Carolina ACCESS Enrollees" was approved by DMA, and a Memorandum of Understanding (MOU) between the Women's and Children's Health (WCHS) and DMA was executed. A Credentialing Workgroup of twenty-two representatives from the WCHS' central and regional offices and local SBHCs assisted the Clinical Services Coordinator with the development of the *Credentialing Standards and Evidence of Performance*, an assessment instrument, and a site visit protocol.

In an effort to build bipartisan support for centers, Making the Grade in North Carolina offered two public relations and marketing workshops this year. Also, representatives from the Leadership Council met with the NC School Boards Association in April to discuss ways of orienting educators, administrators and local communities to coordinated school health programs including school-based health centers. As a result of this meeting, the NC School Boards Association held a series of development programs for school board

members across the state this fall that included a concurrent session on coordinated school health programs and SB/SLHCs. Also, centers across the state collaborated in the formation of the NC Association of SB/SLHCs. Their first annual meeting was held in May with over 200 in attendance.

The six regional school nurse consultants worked within their regions to promote the development and expansion of school health services. These included the provision of technical assistance to local school nurses and other school staff regarding the development and implementation of Individual Education Plans (IEPs), Individual Health Plans (IHPs), and 504 Accommodation Plans for students with special education and health care needs. They conducted meetings for school health program supervisors and coordinators to facilitate networking and the provision of clinical and administrative program updates.

Continuing education for school nurses was provided through the Annual School Nurse Conference, as well as through 2-day orientation workshops for new school nurses. These educational opportunities provided updated information on the changes in IDEA 97, state resources, clinical protocols for managing children with chronic illnesses in the school setting and the importance of local policies regarding medication administration.

The annual School Nursing Survey and Program Summary was conducted to determine the nurse to student ratios, the scope and complexity of health services provided to students, the trends in chronic illness prevalence and the extent of unmet needs. This information was used by the DHHS Ad Hoc Task Force on School Health, appointed by the State Health Director and the Secretary of the Department of Health and Human Services, to develop the following recommendations:

- Establish a long range plan for the development of Coordinated School Health Programs (cshps) in all NC schools,
- Establish additional school nurse positions to bring the school nurse-to-student ratio to the national standard of 1:750 by 2010,
- Create a statewide support system of pre-service, in-service and continuing education for school nurses, and
- Foster ongoing commitment at the state and local levels to collaboration between education, health services and community individuals and institutions.

Capacity-Building/Infrastructure Services: Children With Special Health Care Needs

National Performance Measure #11: Percent of children with special health care needs in the state CSHCN program with a source of insurance for primary and specialty care.

The CSHCN Program was primarily involved in two programmatic endeavors during FY 98-99: the provision of direct and enabling services through its Developmental Evaluation Center (DEC), Child Service Coordination (CSC), and Children's Special Health Services (CSHS) Programs; and improving systems of care for children with particular emphasis on those eligible for early intervention or Medicaid. During this same period, the state began implementation of the CHIP (Health Choice) Program, which provided a new and exciting avenue for improving service delivery to CSHCN.

In addition to establishing parameters for the new child health insurance program, the enabling state legislation included several specific provisions related to children with special health care needs. The legislation included a definition of 'special needs' and outlined additional benefits available to children who meet the definition. In addition, it called for the establishment of the NC Commission on Children with Special Health Care Needs and granted authority to make recommendations for improving services for children with special health care needs in Health Choice and across the state. Staffing the Commission on Children with Special Health Care Needs and developing Health Choice provisions for children with special health care needs is the responsibility of the Women's and Children's Health Section.

Since the benefits package for Health Choice was modeled to match those in the state Medicaid Program (Health Check), we can reasonably assume that CSHCN participating in either Health Choice or Health Check have a source of insurance for comprehensive primary and specialty care. During FY 98-99, Health Choice served as a "learning lab," piloting interventions and approaches that hold potential for replication in the state Medicaid program and the private insurance industry. In this context, Health Choice can influence standards for the provision of primary and specialty services to children with special health care needs in North Carolina.

To date, the following activities have been initiated. Screening tools for parents and providers were developed, with the parent tool included in the benefits and special needs handbooks. Additional benefits available to children with special health care needs were identified and service criteria established. Preliminary research on service coordination and emergency respite care began. An educational booklet outlining services available for children with special needs was drafted. As a component of quality assurance, a survey of parents with children with special needs was developed. This survey will measure health and functional status, participation, and quality of life, as well as other outcomes for children and families participating in three different insurance programs: Health Choice, Medicaid, and the State

Employee Health Plan. The Commission met four times during FY 98-99. The Children's Special Health Services hotline was expanded to serve as a resource for families participating in Health Choice. Mechanisms for identifying children with special health care needs by diagnosis and service utilization were under development. Finally, Health Choice continued to actively engage family participation in all aspects of program and policy development and quality assurance.

National Performance Measure #14: Degree to which the state assures family participation in program and policy activities of the CSHCN program.

The Parent Advisory Council (PAC) of the WCHS Children and Youth Branch provides direct advice on Section/Division policies and their implementation in CSHCN and other child health programs. Parents are particularly effective in advocating for new initiatives (e.g., the new Child Health Insurance Program). Parents routinely critique new educational and training materials, program policy manuals attend program retreats, and are very often presenters in the training of new program staff. In some cases, reimbursement for expenses and stipends for consultation are available.

Families of CSHCN worked with local child service coordinators to ensure that the family centered perspective was present by providing training and support. In addition, support was provided to 13 local Family Support Network programs across the state.

2.5 PROGRESS ON OUTCOME MEASURES

Progress on outcome measures related to perinatal health (National Outcome Measures 1-5 and the state outcome measure) are summarized in TABLE V.

National Outcome Measure #6: Death Rate Per 100,000 Children Ages 1-14

In 1998, North Carolina's child fatality rate was 89.5 per 100,000 – the second lowest rate on record. In addition, 1998 statistics reveal:

- 2% increase in fatalities among 10-14 year olds.
- 57% decrease in motor vehicle fatalities (more than half of which involved passengers).

TABLE IV
Progress on Perinatal Outcome Measures

	Year 2000 Objective	NC Status	Selected Activities
NATIONAL OUTCOME MEASURES			
1. Infant mortality rate per 1,000 live births	7.0	1996 9.2 1997 9.2 1998 9.3	<ul style="list-style-type: none"> ▪ Expansion of fetal and infant mortality reviews ▪ Expansion of Child Fatality Task Force to include Perinatal Health Committee, which will have infant mortality as a focus ▪ CNM projects ▪ Provision of routine and high risk prenatal care services
2. Infant mortality: black/white ratio	1.57	1996 2.4 1997 2.2 1998 2.7	In addition to the efforts described above, targeted infant mortality reduction projects in minority communities
3. Neonatal mortality rate per 1,000 live births	4.5	1996 6.4 1997 6.1 1998 6.5	<ul style="list-style-type: none"> ▪ Expansion of Child Fatality Task Force to include Perinatal Health Committee, which will have infant mortality as a focus ▪ Infant mortality reduction projects, ▪ Family support and case management ▪ Home visiting
4. Post neonatal mortality rate per 1,000 live births	~2.5	1996 2.8 1997 3.1 1998 2.8	<ul style="list-style-type: none"> • Expansion of Child Fatality Task Force to include Perinatal Health Committee, which will have infant mortality as a focus • Family support and case management • Home visiting
5. Perinatal mortality rate per 1,000 live births	~9.5	1996 13.4 1997 14.1 1998 14.5	all of the above
State Outcome Measure			
Maternal mortality ratio per 100,000 live births	N/A	1996 26.8 1997 16.8	all of the above

III APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

Process

Shortly after his appointment in 1997, DHHS Secretary H. David Bruton, MD expressed an interest in developing a “blue print” to guide state agency efforts related to child health. In the spring of 1999, he formally asked the NC Institute of Medicine to assist DHHS in developing a comprehensive child health plan that would:

1. Identify and/or establish measurable health status goals
2. Document current health status of children in the state
3. Identify existing services and programs, and remaining areas of unmet need

Dr. Bruton had a very broad definition of “child health” in mind, beginning in the pre-conceptual period and continuing through adulthood, and he wanted a five-year plan. This definition, and the planned approach to development of the child health plan, meant that the plan would meet the requirements of the Five-year needs assessment.

The Institute of Medicine was asked to coordinate development of the plan to help assure that it was not just another “governmental report” prepared by bureaucrats for bureaucrats. This was very important since Dr. Bruton had announced that his term of service as DHHS Secretary would end in 2000 with the current Governor, and he wanted the plan to represent the objective view of experts familiar with child health issues, current services and priority needs to increase likelihood of “buy in” by future administrations. While prepared under the auspices of the NC Institute of Medicine, DHHS staff (primarily WCHS) actively participated in data collection, analysis, and crafting of the final recommendations. (See report for complete description of the approach used.) Thus the process for development of the plan allowed

The NC IOM convened a panel of experts which was divided into six sub-committees that met monthly from July 1999 to May 2000 to analyze data and make recommendations in the following areas:

1. Perinatal Health
2. Acute Illnesses and Infectious Diseases
3. Chronic Illnesses and Developmental Disabilities
4. Mental Health and Substance Abuse
5. Injuries and Fatalities
6. Health Promotion

The Comprehensive Child Health Plan was formally presented to Dr. Bruton on May 23, 2000. It contains a total of 100 recommendations, including 10 priority actions, needed to maintain critical existing services and/or to develop services needed to address specific needs.

As a complement to the Child Health Plan, needs assessment activities included a in-depth examination of health related needs of youth with disabilities and chronic health conditions and their parents. This was done through a series of twelve focus groups conducted in the spring of 2000 with a respondent group that is reflective of geographic, racial/ethnic, gender, age and disability differences within the target population. Four additional interviews were conducted with young adults with intellectual disabilities to include the unique experiences of this population.

Data collection is complete and the findings are being compiled into a which will include a review of current literature and research related to transition and the health needs of adolescents with special health care needs. Recommendations will address strategies for improving systems of care and promoting participation in basic preventive and health promotion services for youth with chronic health conditions and disabilities in NC. It will also inform future programmatic and policy directions for addressing the transition related needs of adolescents with special health care needs.

An all-day retreat for the Section Management Team and key program managers is scheduled for August 30, 2000 to begin the process of identifying strategies and specific action plans to address recommendations included in the Child Health Plan (and the special needs focus groups). Once the WCHS response to these recommendations is developed, we will consolidate those activities with existing plans to address MCHB performance measures, other Federal and state programmatic requirements, and state legislative priorities. From that assessment, we will determine our 10 priority areas, and revise our state-negotiated performance and outcome measures as appropriate.

Once the above activities have been completed, WCHS will have a consolidated plan for Section-wide planning, intra-agency coordination, and presentation to other partners and interest groups. The initial NC-IOM proposal for completion of the Child Health Plan included plans for regional town meetings to get input on preliminary findings. Time did not permit completion of these activities prior to completion of the plan, however, WCHS is developing plans for wide dissemination of the Child Health Plan and the DHHS/WCHS response to it.

Content

The Executive Summary of the NC Comprehensive Five-Year Child Health Plan is located in Section 5.3 (Other Supporting Documents). The entire document is included as an attachment to the application.

3.2. Health Status Indicators

Priority Needs

The current list of priority needs was developed in 1998, based on review of the 1995 needs assessment, and existing priorities (including gubernatorial and legislative initiatives) for each Section. These priorities will remain in place pending in-depth review of the NC Comprehensive Child Health Plan (our five-year needs assessment), and development of WCHS response. Current priorities are:

1. Strengthening public health infrastructure at state and local level.
2. Improving pregnancy outcomes for all women.
3. Assuring access to care for low income, uninsured and other vulnerable segments of the MCH population.
4. Improving availability and quality of health and health education services available in school settings.
5. Improving nutrition and fitness among children and adolescents.
6. Reducing occurrence and severity of injuries (particularly unintentional injuries) among children and adolescents.
7. Reducing unintended pregnancies
8. Improving childhood immunization coverage (through full implementation of a statewide computerized tracking system)
9. Enhancing monitoring, consultation and technical assistance to regulated child care centers to assure conditions that protect and promote health status of children
10. Assuring coordination of existing and planned home visiting and family support services

TABLE V shows the relationship between priority needs and WCHS activities.

TABLE V
Relationship Between Priority Needs and WCHS Activities

<i>Priority Needs</i>	<i>WCHS Activities and Initiatives</i>
1. Strengthening public health infrastructure at state and local level	Improving regional consultant skills, participating in agency plans for responding to changes in public health delivery system
2. Improving pregnancy outcomes for all women	Care coordination services for pregnant women, support of direct delivery of prenatal services, family planning services, infant mortality reduction projects, smoking cessation education and in-clinic services
3. Assuring access to care	Public information activities related to CHIP implementation, direct delivery of services in DEC's, support of local health department clinical services, care coordination
4. School health	DHHS/DPI infrastructure grant, consultation and technical assistance to state education agency, local school districts and individual schools
5. Improving nutrition and fitness among children and adolescents	WIC, nutrition training for school and child care personnel, Body Works weight management program, nutrition education for parents and caregivers as part of well child care
6. Reducing occurrence and severity of injuries among children and adolescents	Public awareness, public education activities by Division and Child Fatality Task Force
7. Reducing unintended pregnancies	Family planning services, care coordination and follow up
8. Implementation of a statewide computerized tracking system	Implementation of NC Immunization Registry
9. Enhancing services to regulated child care centers	Establishment, maintenance and marketing of Child Care Library, periodic child care bulletins, public information campaigns, Child Care Health Consultant Training Program
10. Assuring coordination of home visiting and family support services	Interagency advisory groups, coordination of services within the Division

3.3 Annual Budget and Budget Justification

See ERP Forms in Section 5.8

3.4 Performance Measures

National Performance Measures See ERP Form 11 in Section 5.8

State “Negotiated” Five Year Performance Measures

Development of State Performance Measures

The state performance measures were selected by the Section Management Team based on the priority needs discussed previously, and priorities of new state health officer and Governor. The measures selected are:

1. Number of substantiated cases of child abuse and neglect
2. Percent of counties covered by standardized fetal and infant mortality reviews
3. Percent of children less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness
4. Percent of children ages 6 months to 6 years with elevated blood levels (≥ 10 micrograms/dL)
5. Percent of women who gained more than 15 pounds during pregnancy
6. Percent of children ages 5-18 who are obese (BMI ≥ 95 th percentile)
7. Percent of children in regulated child care settings that are served by a qualified child care health consultant
8. Percent of children and adolescents in public schools with access to services of a school-based or school-linked health care center
9. Percent of women who smoke during pregnancy
10. Percent of counties with active Child Fatality Prevention Teams

Discussion of State Performance Measures

TABLE VI shows the national and state performance measures by level of the service pyramid, and type of service. TABLE VII summarizes the relationship between the state and national performance measures.

TABLE VI
National and State Performance Measures by Level and Type of Service

National (Core) Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1. The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the state Children with Special Health Care Needs (CSHCN) Program.	X				X		
2. The degree to which the state Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3. The percent of Children with Special Health Care Needs (CSHCN) in the state who have a “medical/health home.”		X			X		
4. Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5. Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6. The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8. The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9. Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10. Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11. Percent of Children with Special Health Care Needs (CSHCN) in the state CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12. Percent of children without health insurance.				X	X		
13. Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				X		X	
14. The degree to which the state assures family participation in program and policy activities in the state CSHCN Program.				X		X	
15. The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
16. Percent of very low birth weight live births.				X			X
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

TABLE VI (con't)
National and State Performance Measures by Level and Type of Service

State Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1. Number of substantiated cases of child abuse and neglect		X			X		
2. Percent of counties covered by standardized fetal and infant mortality reviews		X					X
3. Percent of children less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness			X		X		
4. Percent of children less than 6 with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead			X				X
5. Percent of women who gained <15 pounds during pregnancy			X				X
6. Percent of children 5-18 who are obese (BMI greater than or equal to 95th percentile)			X				X
7. Percent of children in regulated child care settings that are served by a qualified child care health consultant				X	X		
8. Percent of children and adolescents in public schools with access to services of a school-based or school-linked health care center				X	X		
9. Percent of women who smoke during pregnancy				X			X
10. Percent of counties with active Child Fatality Prevention Teams				X			X

NOTE:

DHC = Direct Health Care
 ES = Enabling Services
 PBS = Population Based Services
 IB = Infrastructure Building
 C = Capacity
 P = Process
 RF = Risk Factor

TABLE VII
Rationale for State Performance Measures, and
Relationship to National Performance Measures

State Performance Measures	Relationship to National Performance Measures
1. Number of substantiated cases of child abuse and neglect	Not addressed by NPMs.
2. Percent of counties covered by standardized fetal and infant mortality reviews	Not addressed by NPMs. High priority within the state.
3. Percent of children less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness	High priority of current administration.
4. Percent of children less than 6 with elevated blood levels (greater than or equal to 10 micrograms/dL) of lead	No environmentally related NPMs. Environmental issues are a priority of new state health officer.
5. Percent of women who gained <15 pounds during pregnancy	Expands NPMs related to perinatal health
6. Percent of children 5-18 who are obese (BMI greater than or equal to 95th percentile)	Of special interest in NC where percent population that is sedentary is well above the national average.
7. Percent of children in regulated child care settings that are served by a qualified child care health consultant	Not related to NPMs. Priority for agency.
8. Percent of children and adolescents in public schools with access to services of a school-based or school-linked health care center	Not related to NPMs. Priority for agency.
9. Percent of women who smoke during pregnancy	Expands perinatal focus of NPMs 16, 17 and 18. Addresses issue directly related to poor pregnancy outcome.
10. Percent of counties with active Child Fatality Prevention Teams	Not addressed by NPMs. High priority within the state.

Five Year Performance Targets

Performance targets for national and state performance measures were developed using slightly different techniques depending on data availability and quality. WCHS staff considered trends and expected impact of on-going and planned interventions.

Review of State Performance Measures

The single proposed outcome measure is maternal mortality. Though this is a rare event, tracking it will provide information about a sentinel measure.

IV. ANNUAL PLAN

This section includes information about new program activities, the key issues programs will face, and the ways programs may be modified to better address changing needs. Descriptions of on-going programs provided in the annual report are not repeated.

4.1 Program Activities Related to Performance Measures (in numerical order)

National Performance Measure #1: Percent state SSI beneficiaries less than 16 years old receiving rehabilitative services from state Children with Special Health Care Needs (CSHCN) program.

Our current system, as was described in the Annual Report, is to refer each newly eligible SSI child to the Child Service Coordination program in his local health department. This system has been effective in that previous in-house reviews have indicated that children with disorders such as mental retardation, autism, attention deficit disorder and learning disabilities received services through their local school systems; and that children with mental illness and behavioral problems were referred for review to the Division of Mental Retardation, Developmental Disabilities and Substance Abuse Prevention. Staff there determined that those children were receiving intervention services through either public or private agencies and were recognized by their school systems as exceptional children.

We have further determined that the majority of the SSI children referred are known to the health department, and were already receiving services from Child Service Coordinators, through the public school system and/or other early intervention programs.

During FY 00-01 we will again survey health departments to determine the percentage of new SSI children currently served by them, the percentage unknown to them, and the timeliness with which they are able to offer Child Service Coordination services or referral to a more appropriate agency.

National Performance Measure #2: Degree to which the state CSHCN program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

CSHS does not anticipate any changes that will affect our ability to continue provision of references specialty and sub-specialty services.

National Performance Measure #3: Percent of children with special health care needs who have a “medical/health home.”

In previous years, monitoring performance in regard to this objective was based on data for North Carolina from the 1995 National Health Information Survey - Disability Supplement. While this provided state-specific information on an identified population-based sample of children with special health care needs, this single-point-in-time approach is limited. Furthermore, given our intent to align our program with a more comprehensive definition of medical home, we no longer feel that the data presented in the past was truly reflective. Consequently, an important activity planned for the upcoming year is to continue internal and external discussions on the various ways that medical home can be defined. While conceptually, and for the purposes of program and systems development, we fully support the federal definition of a medical home, the subjective dimensions included in the definition make it challenging to operationalize for purposes of monitoring and quality assurance.

Toward our goal of improving assessment and quality assurance for children with special health care needs, NC is committed to participate in the development and application of identification tools for this population. The current development and validity research for national CSHCN screening tools will let North Carolina identify children with special needs in a way that will allow comparisons with national data. Specifically, the selection of the QuICCC-R, FAACT, or CAHPS screener will let North Carolina move forward in our efforts to develop a prospective method for identifying CSHCN at the point of enrollment for Health Check (Medicaid) and Health Choice (CHIP). With the support of the NC Commission on Children with Special Health Care Needs, North Carolina Title V and the Division of Medical Assistance are committed to modifying the Medicaid/CHIP application to include screening questions.

Once children are identified, it is imperative that we establish better mechanisms for assessing their health related experiences and health status. NC Title V will undertake two major initiatives this year to move toward this goal. North Carolina will participate in the national survey of children with special health care needs sponsored by the Maternal and Child Health Bureau. In an attempt to increase our ability to analyze the data on selected sub-sets of children, North Carolina will increase our survey sample size from 750 to 1200 children.

Complimenting this rich data set, our state will also undertake a survey comparing children with special needs participating in two to three different insurance programs - Health Check (Medicaid), Health Choice (CHIP), and (potentially) the State Employees Health Plan (Blue Cross and Blue Shield of NC). This study will provide insight into the experiences, satisfaction, health and functional status and degree of

family and community participation for CSHCN. This survey will begin in the Fall 2000, with data analysis to be completed by Summer 2001. Our intent is to use the results from these studies to better estimate the degree to which CSHCN in NC have established relationships with a primary care provider and the extent to which these relationships are characteristic of those of a medical home. This will then serve as baseline information for future initiatives.

One initiative that we feel holds great potential for expanding the number of CSHCN receiving care in a medical home is the service coordination benefit available to CSHCN under Health Choice. Included in the enabling legislation and slated for implementation in the upcoming fiscal year, we anticipate that service coordination will be an intensive service available to a sub-set of the population of CSHCN enrolled in Health Choice. According to analysis of the Health Choice claims data, approximately 11% of enrolled children have a diagnosis that would indicate special need. Currently in North Carolina, service coordination is only available to children up to age 5.

A second project also holds potential for increasing the number of CSHCN with medical homes. With the support of the NC Pediatric Society, the five major medical centers in the state are exploring the development of a demonstration project that would place a service coordinator at each medical center to interface between the family, locally-based primary care physicians and other health providers, and pediatric sub-specialists. The goal of the project is to provide a case management based model of comprehensive care for children in NC with cerebral palsy and spina bifida in order to maximize family and community centered care for these patients. This represents another activity to be undertaken by Title V to further enhance partnerships between regional medical centers and community-based providers.

In light of the growing attention towards the importance of medical homes for children with special needs, the NC Title V program is committed to supporting systems of care inclusive of medical homes. In that this will broadly address the needs of CSHCN over age five, this will be a new direction for the Title V program in North Carolina.

National Performance Measure #4: Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, congenital adrenal hyperplasia (CAH), hemoglobinopathies (e.g., sickle cell diseases) combined.

See Annual Report – all described activities will be continued. In addition, the state Newborn Screening Advisory Council, in conjunction with the Division of Public Health, will investigate adding newborn cystic fibrosis and biotinidase screening to the screening services currently provided..

National Performance Measure #5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

During FY 00-01, expansion of the current registry to serve private sector physicians will be a top priority. The current plan is to identify and purchase an existing immunization registry from another state for implementation in both public and private sectors in North Carolina. The Immunization Branch will continue work with public and private partners to achieve this goal.

National Performance Measure #6: The birth rate (per 1,000) for teenagers ages 15-17 years.

See Annual Report – all described activities will be continued.

National Performance Measure #7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Dental sealants are underutilized in North Carolina. Approximately 31% of school children have at least one dental sealant in a permanent molar. The Oral Health Section plans to continue its intensive five-part strategy of public awareness, provider education, sealant demonstration projects, media promotion, and partnering with provider groups. Efforts will be directed toward increasing the percentage of children with dental sealants to 50% by the year 2010.

National Performance Measure #8: Rate of deaths to children aged 1-14 years caused by motor vehicle crashes.

Automobile safety will be a priority for the NC Child Fatality Task Force in FY 00-01. The Task Force has studied the causes of child deaths since 1991, and recommended policy changes to make it a safer place for children. The Task Force has found that motor vehicle crashes continue to be the number one cause of unintentional child fatalities. The Child Fatality Task Force will continue advocating for a comprehensive seatbelt bill, and enactment of a bicycle helmet requirement for every rider aged 12 and younger.

North Carolina's Local Child Fatality Prevention Teams will continue to review all deaths of children ages one to 14 caused by motor vehicle crashes. Prevention recommendations from Local Teams are expected to result in local child restraint awareness campaigns and safety seat distributions.

In addition, state agencies involved in child passenger safety issues have formed a Special Committee to address the problem of injuries to children caused by motor vehicle crashes. This Committee includes staff from NC Child Fatality Task Force, Injury Prevention Unit, Governor's Highway Safety Program and others. The Committee will publicize the child passenger safety laws that are expected to be strengthened in the current legislative session. Committee member organizations (DHHS Injury Prevention Unit and the UNC Highway Safety Research Center) are surveying local child passenger safety programs to compile a current inventory of services and to determine resource needs of local programs including funding, training, and current educational materials. The Committee will work to meet the needs identified by local programs.

National Performance Measure #9: Percent of mothers who breastfeed their infants at hospital discharge.

In addition to the ongoing strategies to promote breastfeeding initiation described in the FY 98-99 Annual Report, the following new strategies will be implemented to increase the breastfeeding initiation rate:

- Continue to offer the North Carolina Lactation Educator Training Program two times a year.
- Offer a one-day training, regionally, to front-line employees (i.e., management support staff working in WIC Program clinics.
- Seek nominations for "Mother-Friendly Business Leaders" who support breastfeeding at the worksite and recognize with a certificate of appreciation from NC DHHS. Develop resource materials for businesses interested in becoming more "Mother-Friendly".
- Develop and distribute a training module targeted for childcare providers on what to know about breastfeeding babies and about handling pumped breastmilk.
- Summarize and disseminate the results of a local agency survey designed to identify best practices for promoting and supporting breastfeeding at the local level.
- Distribute electric breast pumps and accessory kits purchased with WIC Program food dollars to local WIC agencies throughout the state. These pumps and kits are loaned as needed to breastfeeding women who participate in the WIC Program.

National Performance Measure #10: Percent of newborns who have been screened for hearing impairment before hospital discharge.

A temporary rule made neonatal physiologic hearing screening become a required service for all newborns in North Carolina as of October 1, 1999. However, numerous birthing facilities did not implement screening programs until January 2000 or later due to the severe damage caused to this state by the hurricanes and resultant flooding in 1999. The permanent rule, which will go into effect on August 1, 2000, has been modified to require that all birthing facilities maintain the equipment necessary to perform hearing screenings prior to discharge.

National Performance Measure #11: Percent of children with special health care needs (CSHCN) in the state CSHCN program with a source of insurance for primary and specialty care.

During FY 00-01 the state CSHCN program -- Children's Specialized Health Services (CSHS) -- will begin the process of broadening our approach to defining children participating in the Title V CSHCN program. The reasons for this are many. First, the Developmental Evaluation Centers have been transferred to the newly created DHHS Division of Early Intervention and Education. Second, CSHS has determined the need for a less programmatic approach to defining children served through Title V and will instead look at broad populations of special needs children. Lastly, new data collection activities will allow CSHS to identify and gather information on special needs children in a manner consistent with the national MCHB definition.

CSHS will continue to aggressively enroll special needs children in the state Medicaid (Health Check) and CHIP (Health Choice) programs through state and community level outreach efforts. (See National Performance Measure #12.) The NC Commission on Children with Special Health Care Needs sought a number of legislative changes to the CHIP program during the current (2000) legislative session. Proposals include elimination of the 2-month waiting period (uninsured period) for *all* children, and most especially for children with special health care needs. This change has been included in the Governor's legislative agenda and budget proposals.

The Commission also devoted a great deal of attention to the number children with special health care needs who remain uninsured or under-insured. During FY 00-01, CSHS will support the Commission's continuing efforts to enhance health insurance coverage for special needs children.

In addition, CSHS will focus additional energy on benefits education for families enrolled in Health Check and Health Choice. Particularly for families new to the rich benefits package available under these programs, there is a need for education regarding what benefits are available and on how they can best be

accessed. Other mechanisms for achieving this goal include: continued development of the Special Needs Helpline, Family Health Resource Line, and Family Support Network resources and referral services; provider education; educational materials development and dissemination; training of other community service providers; and the implementation of care coordination.

National Performance Measure #12: Percent of children without health insurance.

The major initiative planned for FY 00-01 to address the issue of children without health insurance is continued aggressive efforts toward outreach and enrollment of children in both the Health Check (Medicaid) and Health Choice (CHIP) Programs.

In addition, we will reassess Health Choice re-enrollment processes to assure ease and friendliness. North Carolina applied for the Robert Wood Johnson "Supporting Families through Welfare Reform" Grant to specifically focus on our re-enrollment process. Families will be surveyed who have failed to re-enroll to determine the reasons.

During FY 00-01, we will highlight "best practices" to encourage modeling of successful outreach strategies, plus we are benefiting from the lessons learned and tools being developed by our Robert Wood Johnson and Duke Endowment grant-funded pilot projects.

We have moved from general, broad-based outreach strategies to more targeted approaches including outreach to higher income populations, minority populations and families who have children with special health care needs. (Approximately 70% of the children enrolled in Health Choice come from families whose income is $\leq 150\%$ FPL, compared to 30% whose income is $>150\%$ FPL and $\leq 200\%$ FPL. According to the NC Division of Medical Assistance (Health Choice administrative agency), the penetration rate for the children we estimated to be eligible at $\leq 150\%$ FPL is 108%, as compared to 48% for the children estimated to be eligible at $>150\%$ FPL. Thus targeting outreach efforts to non-traditional users of publicly-funded services is an important goal for FY 00-01.)

National Performance Measure #13: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program.

Integrating Health Check and Health Choice Programs will be a high priority for FY 00-01. Health Check Coordinators will continue to provide outreach for both programs. Several media campaigns are planned, with an emphasis on promoting the programs to minority populations.

The state will develop a comprehensive education approach promoting utilization of preventive care and achievement of long-term health outcomes for children and adolescents enrolled in Health Check

and Health Choice. This effort will be integrated with the Health Check and Health Choice Campaign Office. Materials to support this approach will be developed for dissemination at the state and community level as an ongoing component. These activities will be performed in collaboration with the Division of Medical Assistance and with the oversight of the State Outreach Committee.

The role of existing Health Check Coordinators in 60 project counties will continue to be redefined and broadened to include a greater emphasis on outreach for children eligible for services through Medicaid and Health Choice. The Health Check Coordinators will also play a vital in promoting the importance of preventive health care.

The Health Check Project Management Team will develop strategies for expanding Health Check Coordinators statewide. (Currently, there are approximately 100 Health Check Coordinators in 60 counties.) Appointment reminder letters generated by the Automatic Information and Notification System (AINS) will be revised to include increased attention on consumer education and to strengthen the link between a child and his/her primary care provider.

National Performance Measure #14: Degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Activities described in FY 98-99 Annual Report will be continued. In addition the Children and Youth Branch Parent Advisory Council will develop strategies to increase racial/ethnic diversity on the Council by increasing participation of under-represented groups.

National Performance Measure #15: The rate (per 100,000) of suicide deaths among youths aged 15-19.

In FY 00-01, the Local Child Fatality Prevention Teams will continue to review all suicide deaths of children ages one to 17. These local reviews have resulted in an increased awareness of adolescent suicides and suicide prevention at the local level. Based upon recommendations from the Local Child Fatality Prevention Teams, the NC Child Fatality Task Force has advocated for strong gun storage laws.

Also, the membership of the Youth Suicide Prevention Task Force will be expanded in FY 00-01 to include all critical members needed for developing a state prevention plan. A plan will be developed with input from a broad range of contributors from throughout the state. The plan will be published and presented to various agencies and organizations for their involvement in implementing the various program components. Funding sources for various components of the plan will be identified and approached for financial support.

National Performance Measure #16: Percent of very low birth weight live births.

Activities described in FY 98-99 Annual Report will be continued.

National Performance Measure #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Activities described in FY 98-99 Annual Report will be continued.

National Performance Measure #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

Activities described in FY 98-99 Annual Report will be continued. Some deterioration in this measure is possible if Medicaid managed care leads to a substantial shift of low income clients into the private sector, particularly if more private providers without previous experience in serving Medicaid clients participate. Clients may not be familiar with the location of new providers, new transportation difficulties may be encountered, effective outreach may not be carried out. In addition, the capacity of some local health departments to provide services to non-Medicaid eligible clients may also be compromised if departments lose substantial amounts of Medicaid revenues. In some parts of the state this capacity is already being stretched because of an increasing influx of Hispanic clients.

State Performance Measure #1: Number of cases of substantiated child abuse and neglect

The home visiting demonstration projects in place in seven counties will continue during FY 99-00. At least six additional projects will be implemented through collaboration between the Division of Public Health and the NC Office of Juvenile Justice. These new projects will work with local juvenile court counselors to assure that any pregnant young women in the juvenile court system will be receive appropriate support services. The NC Child Fatality Task Force and other advocacy organizations have made expansion of these initiatives a priority. Planning, implementation and evaluation activities will be conducted with the existing projects and with new projects.

The NC Family Support Training and Credentialing Initiative, which has been developed by the NC Family Resource Coalition, will continue to provide interagency, competency-based training for family support workers in a number of locations across the state. The NC Child Fatality Task Force will support policy and budget priorities to reduce child injuries and fatalities, including full funding for intensive home visiting.

WCHS will continue to support existing activities designed to strengthen families, and to reduce morbidity and mortality associated with child maltreatment. WCHS in-kind support of the NC Family Resources Coalition includes staffing for the Coalition and other services. During FY 00-01, up to 600

front line workers, supervisors and family leaders will complete the Empowerment Skills for Family Workers training. Training and leadership opportunities will also be made available through the Family Leadership Development Initiative of the Coalition. These trainees will work with other families in their communities. WCHS will work with the state Medicaid to obtain approval for Medicaid reimbursement of program services. If this Medicaid approval is granted, this reimbursement will serve as a means of assuring statewide expansion of the program through use of state funds for start-up costs.

State Performance Measure #2: Percent of counties covered by standardized fetal and infant mortality reviews (FIMRs)

Activities described in FY 98-99 Annual Report will be continued.

State Performance Measure #3: Percent of children in the state less than 3 years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.

During FY 98-99, the state Interagency Coordinating Council (ICC) began planning for a comprehensive assessment to determine the extent to which children enrolled in early intervention are getting their service needs met under managed care. Project activities include surveying families living in parts of the state where managed care has been active the longest and investigated both Medicaid and private managed care. As part of this effort, CSHS will collect data to monitor the percent of children less than three years old enrolled in early intervention receiving physical, occupation, speech-language, or nutrition therapy. This measure is important because it indicates the extent to which children enrolled in the NC Infant-Toddler Program (Part C of IDEA, Individuals with Disabilities Education Act) are actually receiving needed treatment services. In addition, IDEA legislative requirements mandate the provision of early intervention services, including treatment services, that are documented in a child's IFSP (Individualized Family Service Plan). The state's network of Developmental Evaluation Centers continues to serve as the lead agency for multidisciplinary evaluations required for entry into the Infant-Toddler Program.

An FY 98-99 ICC review of the early intervention system yielded recommendations to improve this system, including the creation of an integrated data system and creation of transdisciplinary teams to provide technical assistance. These initiatives will be implemented during the July 1, 1999 – June 30, 2001 biennium, since they have received legislative approval. The integrated data system will allow quick access by all agencies serving children 0-5 with special needs.

The primary purpose of the transdisciplinary teams will be to provide technical assistance, training and other support to existing early intervention agencies and providers. They will serve as a communication link between the state agencies and local providers in order to enhance the agencies awareness of the needs of different target populations. Initially, the teams will focus on children with low incidence disabilities, including: visual impairments; hearing impairments; autism; and/or mental health needs.

*State Performance Measure #4: Percent of children ages 6 months to 6 years with elevated blood lead. (≥ 10 **ng/dl**)*

The Division will reduce the prevalence of elevated blood lead levels by:

- Promoting the availability of blood lead analysis at no charge through the State Laboratory of Public Health.
- Conducting three training workshops for local health departments and private clinic staff to increase awareness of lead hazards, and to encourage screening of all children under six years of age.
- Conducting site visits to promote screening at private medical providers statewide throughout North Carolina, focusing on practices whose clientele have the highest rate of childhood lead poisoning.
- Allocating funds to local health departments to provide medical and environmental follow-up of lead poisoned children.
- Working closely with WIC clinics statewide to screen young children not screened in their medical home.
- Setting the action level for rescreening (diagnostic testing), educational intervention, environmental assessment and follow-up activities for children with elevated blood lead levels at 10 ug/dL.

State Performance Measure #5: Percent of women who gained more than 15 pounds during pregnancy.

In addition to the ongoing strategies to promote adequate maternal weight which include assuring that every woman who attends prenatal care in the public health departments and/or who receives WIC Program services, has her weight gain monitored and is counseled on the importance of gaining adequate weight during pregnancy; in FY 00-01, we will be identifying additional ways to assure that an increased number of pregnant women gain at least 15 pounds during pregnancy.

State Performance Measure #6: Percent of children aged 5-18 years who are obese (BMI \geq 95th percentile).

In FY 00-01, WCHS will implement the following strategies to address childhood obesity:

- Conduct a statewide pediatric obesity symposium to raise awareness about the issue of obesity and primary prevention and treatment strategies being implemented in the state.
- Convene a multidisciplinary expert panel to develop a state plan to address pediatric obesity including: public awareness, primary prevention, treatment services, and data collection/evaluation.
- Complete an outcome evaluation of the BodyWorks Weight Management Program that is offered through school-based and school-linked health centers.
- Provide training to health professionals on effective weight management strategies for children with a focus on underlying contributors to obesity including genetics, lifestyle behaviors, limit setting, emotional overeating and family relationships.
- Collaborate with the Chronic Disease Prevention and Control Section on submission of a grant to CDC for the primary prevention of pediatric obesity.

State Performance Measure #7: Percent of children in regulated child care settings that are served by a qualified child care health consultant.

In FY 00-01, the Healthy Child Care initiative activities will include:

- Child Care Health Consultant Training Program in all 100 counties.
- Development of a database for the statewide Child Care Informational and Referral Hotline.
- Marketing the Child Care Library resources to Child Care Consultants.
- Publishing and distributing a *Family Child Care Health and Safety Bulletin*.
- Publishing and distributing a *Child Care Health and Safety Calendar* to Centers.

State Performance Measure #8: Percent of children and adolescents attending public schools with access to services of a school-based or school-linked health center.

During FY 00-01, School Health staff will collaborate with the Division of Mental Health and Substance Abuse Services to expand the behavioral health and education support services provided in 24 school-based programs; and to establish 24 planning initiatives to provide comprehensive health services, i.e., primary care, behavioral health and education support services in elementary, middle and high schools.

WCHS will work with the Division of Information and Technology to develop an information system to replace the existing data collection system (*School Health Online*). The new system will provide an interface between the management information system used by local public health agencies and that used by School-based/School-linked Health Centers to report service activities and meet their own internal needs (including a clinical record keeping system).

State Performance Measure #9: Percent of women who smoke during pregnancy.

In addition to continuation of the activities described in FY 98-99 Annual Report, pilot testing of the perinatal tobacco use and dependency treatment program in managed care organizations based in three counties (ACCESS II sites) and will be implemented during FY 00-01. As will revision of *The Guide for Counseling Women Who Smoke*. The American College of OB/GYN (ACOG) will collaborate with WCHS staff to revise and update this behavior change model in preparation for ACOG recommendation that members use the “The Guide” as the model of treating clients with perinatal tobacco use and dependency.

State Performance Measure #10: Percent of counties with active Child Fatality Prevention Teams

One hundred percent of all North Carolina counties currently participate in the Local Child Fatality Prevention Team review process. However, all Teams do not meet on a regular basis or consistently submit reports of review findings. Statewide training and technical assistance will continue to be provided to all local Teams during FY 00-01. In addition, individual “Coaching Sessions” will be made available to all Teams upon requests.

4.2 Other Program Activities (by type of service and target population)

Direct Care Services:

Pregnant Women And Infants

An important issue facing WCHS is the evolution of Medicaid services toward one or more forms of managed care. We expect that many key decisions in this area will be made by the state Medicaid program (in collaboration with many partners including WCHS). This issues include, for example, how rapidly the state’s Division of Medical Assistance (DMA) will implement managed care across the state, or what managed care models it will institute--it is currently experimenting with several in different parts of the state; and how any changes will be phased in (some form of managed care in every county of the state or mandatory enrollment in selected counties). Given the proposals currently under consideration, it is likely that, unless they opt to become primary care providers, local health departments will provide fewer

direct clinical services to Medicaid clients. If Medicaid service provision in health department clinics declines, these clinics may be unable to meet the needs of persons who are ineligible for Medicaid, particularly the state's increasing Latino population. In addition to the financial barriers faced in serving the Latino population, there are also barriers to overcome in providing culturally appropriate services. Health departments have a hard time recruiting and sustaining bilingual staff. Many Latino women do not routinely obtain preventive health services, but instead wait until they are pregnant to seek services, thereby missing opportunities for preconceptional health services.

The extent of refocusing on enabling or population-based public health functions remains to be seen, but these issues are likely to be the subject of more discussions during FY 00-01. Much of the interaction with DMA concerning managed care policy occurs at the level of the State Health Director's office rather than within the Section. There are ongoing efforts to work with DMA to address these and other key issues, such as standards development and accountability. Section representatives have participated in DMA reviews of the applications of prospective Medicaid managed care providers and have discussed clinical standards and accountability approaches with DMA staff, but have not been wholly satisfied with the progress to date in these areas.

During FY 00-01, WCHS will continue to work very closely with the North Carolina Association of Local Health Directors as they plan for the changes local departments will undergo in the near future. Coordinated planning by the local departments is probably made more difficult by their long-standing tradition of autonomy, their number (eighty-six) and their great disparities in size and capacity. One of the major changes is the conversion of the Health Services Information System, the computerized data collection and billing system used by the health departments, to a system using CPT and ICD-9 codes for reporting and billing. This modification of the current system of reporting/billing, which will take effect July 1, 2000, will enable health departments to bill private insurance companies and "unbundle" services for DMA billing. While this change will allow health departments to charge for their care based more on a cost per service scale when it comes to private insurance companies, it appears that the total reimbursement from Medicaid for direct prenatal clinical care per client may be less.

The Annual Report contains a discussion of Section concerns relating to the High Risk Maternity Clinic program. The Section is continuing to assess the current model high risk maternity care delivered. A task force is being reconvened to devise the best plan for transitioning all truly high risk maternity care to the tertiary care centers without jeopardizing the delivery of care system for the women with low and

moderate risk prenatal care needs as well. It is hoped that resources freed up from this program may be reallocated to support the planned statewide system of region-based fetal and infant mortality reviews.

In the Nurse Midwifery program, the Section plans to continue to fund planning grants as discussed in the Annual Report, in the hope of receiving more carefully planned applications to consider for funding. The Section is exploring the possibility of contracting with a nurse midwife practice specialist to provide the very specialized technical assistance new projects often need and the troubleshooting consultation that existing projects require on occasion. The Section is also interested in conducting an evaluation of the funded projects, both past and current, to determine what elements help make a successful practice.

Children With Special Health Care Needs

North Carolina is rapidly implementing fully capitated Medicaid managed care, including CSHCN. The Division is aware of the challenges involved with serving CSHCN in managed care systems and is concerned about the impact that these new delivery systems will have on the quality of care provided to them.

The operational and financial structures of managed care organizations have the potential to improve access to primary care, as well as to enhance the continuity and coordination of services for CSHCN who depend on an array of providers for their care. However, the financial incentives to underserve these children and the limited specialized providers and services available in most networks may counteract these potential advantages. Close monitoring is needed to assure that CSHCN are able to take advantage of managed care's potential benefits without being hurt by its risks.

Enabling Services

Pregnant Women And Infants

The Section planning for FY00-01 concerning enabling services for women continues to focus on the most effective ways of providing care coordination and home visiting services. This planning has addressed both relatively narrow issues and very broad ones. At the narrow end of the spectrum, the Section is planning to better integrate care coordination and home visiting services provided antepartum with those provided to the family after the child is born. In parts of the state where new appropriations have established new home visiting programs, the Section is working to coordinate the operation of old and new programs.

In a somewhat broader context, the Section has critically reviewed the existing Maternity Care Coordination (MCC) and Maternal Outreach Worker (MOW) programs, as discussed in the Annual Report. Based on this analysis and a review of relevant literature, the Section is interested in implementing several changes in the way these programs are administered. There is a strong desire to titrate the intensity of support services to the client's needs and interests. The current Medicaid reimbursement methodology reimburses providers the same amount per month whether one or many visits are provided. In practice, this has resulted in a significant number of clients receiving the minimal one contact per month. This will need to be changed. There is a consensus that the use of a risk assessment tool is the best way to determine the intensity of service suitable for each client and that the risk assessment tool should delineate specific support services pathways. The actual content of the encounters which make up the various support services pathways should be protocol-driven, giving a specificity to the encounters that has not existed up to this time.

Children

In addition to ongoing programs described in the Annual Report, additional activities are planned for FY 99-00. First, the Section will develop and begin implementation of a three year strategic plan to launch and maintain public awareness activities in support of the NC Health Check and Health Choice programs. An Outreach Specialist position will be created to assume leadership for development and appropriate integration of NC Health Choice Program public awareness activities with maximum utilization of the existing infrastructure for children's services.

In FY 99-00, the following activities will be conducted to support parenting and child health services:

- Local parenting educators will be trained through the Nurturing Program, a curriculum which focuses on prevention of and intervention for child abuse and neglect. An annual parenting education institute will be convened.
- The Fatherhood Development Advisory Committee will continue and expand its services and training capacities to offer an annual conference and to provide statewide technical assistance on request.
- Pilot support programs will be implemented within federal and state correctional facilities.
- The promotion of Child Health Month (October) will continue for the fourth consecutive year, through the statewide "Pull the Plug on Media Violence" campaign.

Other Populations: Women of Reproductive Age

The Adolescent Pregnancy Prevention Program (APPP) was described in the Annual Report. Its origin as a demonstration project and the Division's ongoing plan to move it away from pure demonstration and toward replication of successful interventions was described and will continue in FY 99-00.

Population-based Services

Pregnant Women And Infants

The many activities described in the Annual Report account of the First Step Public Awareness campaign and the Back to Sleep Public Information Initiative will continue in FY 99-00. A more targeted infant mortality reduction campaign will be implemented in the eastern part of the state in association with the "Baby Love Plus" Healthy Start Initiative.

The award-winning Minority Infant Mortality Reduction Public Awareness Campaign described in the Annual Report will evaluate its current campaign, targeted to African Americans, and will explore ways to expand African American-focused activities. A component of the campaign which will focus on the Hispanic community will be developed and an advisory group which will focus on Native American issues will be formed.

During FY 99-00, WCHS will continue to work with the March of Dimes (MOD) and the NC Neural Tube Defects Prevention Task Force to support the Folic Acid Campaign. The NC Chapters of the MOD recently submitted a grant proposal to the national MOD office on behalf of the Task Force which asks for \$300,000 over three years to expand public and professional folic acid education. Recent data from the NC Pregnancy Risk Assessment Monitoring System survey indicate that less than 25% of women in NC take a folic acid containing vitamin on a daily basis.

Capacity Building/Infrastructure Activities

Overview

In FY 99-00, the Section will continue its efforts to support the institutionalization of smoking cessation efforts. The Perinatal and Neonatal Educators have been trained in the use of the "Guide for Counseling Women Who Smoke" (see Annual Report), and these twenty full-time trainers will incorporate smoking cessation programs into the menu of training events they will offer across the state. The Section is also exploring opportunities to link with Medicaid managed care providers to institutionalize smoking cessation counseling services among managed care providers.

A few other capacity building activities the Section will carry out in FY 99-00 should be mentioned briefly. The Section has implemented the revised set of prenatal care standards and will work to ensure that these standards are modified as needed to continue to reflect best practices. The Section continues to revise and improve the MCH accountability system described in the Annual Report. Local health departments received data in FY 98-99 concerning their standing with respect to the set of “process/outcome” measures which are the basis of the accountability system. A revised ranking system is being developed and data will be distributed again in the fall of 1999. Local health departments are expected to utilize this information as they plan the allocation of the funding available to them. The Section looks forward to utilizing findings of the PRAMS process and also preliminary findings from the “Baby Love Plus” Healthy Start Initiative. The Section also plans to develop further information about health behaviors in North Carolina as an aid to its strategic planning, possibly by adding a set of questions to the Behavioral Risk Factor Surveillance Survey.

Children

Asthma is a common condition in childhood with serious consequences such as hospitalization, emergency department visits, and prescription medications resulting in increased medical care cost. Though the prevalence of asthma among children in the United States can be estimated from national surveys, there is little data available on asthma prevalence at the state and local level. WCHS

Medicaid claims paid by NC Medicaid during July 1997-June 1998 (the state fiscal year) were used to estimate the prevalence of asthma among children. During state fiscal year 1997-1998, more than 69,000 children in the Medicaid program ages 0-14 years had a diagnosis or used a prescription drug for asthma. This represented 12.5% of the total children ages 0-14 years who were enrolled in Medicaid. For children ages 0-4 years the figure was 16%. The information (data) on emergency room visit rates are not available. More accurate data on asthma prevalence at the state and local level are needed to look at the deleterious effects of asthma and to evaluate the effectiveness of state-based asthma control and management programs.

Other Populations: Women of Reproductive Age

For the past several years, the Division of Public Health has advocated for the submission of a Medicaid waiver which would significantly expand the coverage of women in need of family planning services. The Department of Health and Human Services has been very supportive of this effort to expand Medicaid eligibility for family planning services only to all women up to 185% poverty. At this time (July 2000), it appears that men will also be covered. The Division of Medical Assistance is taking the lead in

developing the waiver with continued assistance from the Division's Women's Preventive Health Unit. Support for the waiver is based on the evidence that the benefits of increased access to family planning will include improved health and financial stability among North Carolina citizens. Current plans call for the submission of the waiver proposal to the North Carolina General Assembly in the spring of 2000 and subsequent review by HCFA.

4.3 Public Input

The applications will be available for public review at four Regional Offices and at the Division Office July 10-14, 2000 and August 7-11, 2000. The application and the Comprehensive Child Health Plan will be posted on the DHHS/WCHS website (<http://wch.dhhs.state.nc.us>).

Preliminary public input into was obtained by staff discussion with existing advisory groups (e.g. Parent Advisory Council) and at other collaborative meetings (e.g. regional state Smart Start health work groups). Additional public input will be sought after development of the WCHS response to the Comprehensive Child Health Plan.

4.4 Technical Assistance

Technical assistance needs during FY 00-01 will center around assessment of WCHS organization, structure and functioning in the wake of changes in agency structure and personnel changes that resulted from these changes and planned retirement of key management team members.

V. SUPPORTING DOCUMENTS

5.1 Glossary

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for CSHCN - Those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)]*

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year’s MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *[Title V Sec. 501(b)(4)]*

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (For budgetary purposes) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. **(For planning and systems development)** Those children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development, to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - Authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - A group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - Services provided within the context of a defined community.

Community-based Service System - An organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - The recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - The ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - Women who received a medical care procedure associated with the delivery or expulsion of a live birth or fetal death (gestation of 20 weeks or greater).

Direct Health Services - Those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care: inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Family-centered Care - A system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) - The moneys provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - The entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Local Funding (as used in Forms 2 and 3)-Those moneys deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. *[Title V, Sec. 501 (b)(2)]*

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining:

- 1) What is essential in terms of the provision of health services;
- 2) What is available, and
- 3) What is missing.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, AIDS moneys, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - A narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - Activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - The provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor

results should answer the question, “Why should the State address this risk factor (i.e., what health outcome will this result support)?”

State - As used in this guidance, includes the 50 States and the 9 jurisdictions of the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

State Funds (as used in Forms 2 and 3) - The State’s required matching funds (including overmatch) in any given year.

Systems Development - Activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - The process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration, and identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State’s Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State’s Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State’s Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the **Federal** Title V Block Grant allocation, the **Applicant’s** funds (carryover from the previous year’s MCH Block Grant allocation - the unobligated balance), the **State** funds (the total matching funds for the Title V allocation - match and overmatch), **Local** funds (total of MCH dedicated funds from local jurisdictions within the State), **Other** Federal funds (moneys other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and **Program Income** (those collected by State MCH agencies from insurance payments, MEDICAID, HMO’s, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building,” “Population Based Services,” “Enabling Services,” and “Direct Medical Services.”

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain Federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. Sect. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

- (e) Notify the agency in writing within 10 calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
 Office of Management and Acquisition
 Department of Health and Human Services
 Room 517-D
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this

Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Detail Sheets

5.8 All Other Forms

5.9 National Performance Measure Detail Sheets

5.10 State Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

APPENDIX